Hampshire County Council

Oakridge House Care Home with Nursing

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection was unannounced and took place on the 17, 18 and 19 May 2016.

We carried out an unannounced comprehensive inspection of this service on 16 and 17 December 2014 where one regulatory breach was identified. Following this inspection the provider wrote to us to say what they would do to meet these legal requirements. During the inspection we checked whether the provider had completed their action plan to address the concerns we had found. The provider had made the required improvements to address the original concerns; however at this inspection we identified some other improvements were required.

Oakridge House Care Home with Nursing 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. This also included 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 91 people were living in the home.

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 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.

Our inspection of December 2014 found that the planning and delivery of care did not ensure the welfare and safety or people using the service as care plans and records did not always reflect people's current needs. At this inspection we found that improvements had been made and all the areas identified had been appropriately addressed. Care plans contained suitable guidance to allow staff to care for people in a safe and effective way including updating people's care plans regularly to ensure they reflected people's changing needs.

Relatives of people using the service told us they felt their family members were cared for safely. Staff understood and followed the provider's guidance to enable them to recognise and address any

safeguarding concerns about people.

People's safety was promoted because risks that may cause them harm had been identified and guidance provided to manage these appropriately. People were assisted by staff who encouraged them to remain independent. Appropriate risk assessments were in place to keep people safe.

Robust recruitment procedures were in place to protect people from unsuitable staff. New staff induction training was followed by staff spending a period of time working with experienced colleagues to ensure they had the skills required to support people safely.

Contingency plans were in place to ensure the safe delivery of care in the event of adverse situations such as a loss of accommodation as a result of fire or floor. Fire drills were documented, known by staff and practiced to ensure people were kept safe.

People were protected from the unsafe administration of medicines. Nurses and staff responsible for administering medicines had received training and were subject to competency assessments to ensure people's medicines were administered, stored and disposed of correctly.

People received sufficient food and drink to maintain their health and wellbeing however they were not always supported in a timely fashion during meal times. Meal times could take place over an extended period of time with some people not receiving the care they required as detailed in their support plan to enable them to eat in a timely way. The registered manager was aware of this and had taken action to recruit general assistants to support people at meal times. More time was needed to ensure these improvements were fully implemented and sustained.

People were supported by staff who had received an effective induction and period of support from more experienced members of staff. This enabled them to acquire the skills and confidence to deliver safe effective care. Regular supervisions ensured that staff were able to express any concerns they had about their role or ask any questions and they felt supported as a result.

People were supported by staff to make their own decisions. Staff were able to demonstrate that they complied with the requirements of the Mental Capacity Act 2005 when supporting people. This involved making decisions on behalf of people who lacked the capacity to make a specific decision for themselves. Documentation showed people's decisions to receive care had been appropriately assessed, respected and documented.

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

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. Appropriate applications had been submitted to the supervisory body to ensure that people were not being unlawfully restricted.

Staff demonstrated they knew and understood the needs of the people they were supporting. People told us they were happy with the care provided. The registered manager and staff were able to identify and discuss the importance of maintaining people's respect and privacy at all times.

People had care plans which were personalised to their needs and wishes. They contained detailed

information to assist staff to provide care in a manner that respected each person's individual requirements. Relatives told us and records showed that they were encouraged to be involved at the care planning stage, during regular reviews and when their family members' health needs changed.

The provider sought to engage people in meaningful activities however there were insufficient activities hours available and provided to ensure that people receiving support in their rooms always received one to one interaction from activities staff. Staff understood the importance of preventing people suffering from isolation and ensured that they offered companionship where possible. The registered manager recognised the need for more personalised interaction with people in their rooms and was due to introduce more sensory based activities specifically catering for people unable or unwilling to participate in group activities. More time was needed to ensure that this planned improvement would be fully implemented and sustained.

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 and participation in customer survey questionnaires.

The provider's values were provided to people in their service guides and known by staff. Staff demonstrated they knew these standards and we could see these standards were evidenced in the way care was delivered.

The registered manager and staff promoted a culture which focused on providing care in the way that staff would wish to receive care themselves. The registered manager provided strong leadership and fulfilled the requirements of 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. Quality assurance processes were in place to ensure that people, staff and relatives could provide feedback on the quality of the service provided. People were assisted by staff who were encouraged to raise concerns with the registered manager.

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 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.

Risks to people had been identified, recorded and detailed guidance provided for staff to manage these safely for people.

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 able to eat and drink enough to maintain their nutritional and hydration needs. However people were not always supported to enjoy their food in a timely fashion. Some people did not always receive the assistance they required at the time they required.

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

People were supported to make their own decisions and where they lacked the capacity to do so staff ensured the legal requirements of the Mental Capacity Act (MCA) 2005 were met. Staff understood the principles of the MCA and the registered manager demonstrated an understanding of the Deprivation of Liberty Safeguards (DoLS).

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.

Relatives and those with legal authority to represent people were involved in planning people's care. This ensured that people's needs and preferences were taken into account when developing their care plans.

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

Is the service responsive?

Requires Improvement

The service was not always responsive.

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 not always sufficient numbers of activities staff to ensure all people received personalised one to one interaction when unable to participate in group activities. Staff were aware of the risk of social isolation and when possible ensured people had some positive interaction on a daily basis other than during care delivery.

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?

Good

The service was well led.

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

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

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 provider and registered manager regularly monitored the quality of the service provided so that continual improvements could be made.

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 17, 18 and 19 May 2016 and was unannounced. The inspection was conducted by two inspectors, a pharmacist inspector, a Specialist Advisor and an Expert by Experience.

A Specialist Advisor is someone who has specific knowledge, experience and understanding of a particular aspect of care. The Specialist Advisor was a nurse who had extensive experience and knowledge of caring for people living with dementia. The Specialist Advisor reviewed people's care plans to ensure their health needs were being met, spoke with staff, observed meal time sittings and interactions between staff and people living at the home.

An Expert by Experience is a person who has personal experience of using or caring for someone who use this type of care service, on this occasion they had experience of family who had received nursing care. The Expert by Experience spoke with people using the service, their relatives, 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. The provider had also completed a Provider Information Return (PIR) before the inspection. A PIR is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

During the inspection we spoke with seven people, seven relatives, three nurses, the chef and catering

assistant, one activities coordinator, 16 care staff, the deputy manager and assistant deputy manager and the registered manager. We looked at 19 care plans, six of these people's associated daily care notes, six staff recruitment files, staff training records and 12 medication administration records (MARS). We also looked at staff rotas for the dates 2 May to the 29 May 2016, 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.

After the inspection we spoke with a healthcare professional who works closely with the home.

Good

Is the service safe?

Our findings

People, relatives and a healthcare professional we spoke with told us that people living at Oakridge House Nursing Home were safe. On person told us, "Yes (I'm) very safe, looked after by staff day and night". A relative said, "(my family member is) utterly safe here, they (staff) care and listen, the attitude of the staff is fantastic". A healthcare professional told us, 'Care is delivered in a safe way, I have observed staff using correct moving and handling techniques and have good infection control practice. Risk assessments are understood and completed and the home complies well with the provider's falls protocol'.

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 also able to describe the physical and emotional symptoms people suffering from abuse could exhibit. Staff were knowledgeable about their responsibilities when reporting safeguarding concerns within the home. The provider's policy provided guidance for staff on how and where to raise a safeguarding alert. Staff received training in safeguarding vulnerable adults and were required to refresh this training annually. The manager was aware of when a safeguarding alert was 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.

Risks to people's health and wellbeing were identified and guidance provided to mitigate the risk of harm. All people's care plans included their assessed areas of risk for example, mobility and safety, risks associated with people's medical and emotional wellbeing, and peoples nutritional and personal care risks. 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 transferred. Staff knew these risks and were able to demonstrate when supporting people how they ensured people's safety. Other people who required the use of bed rails in order to keep them safe had these appropriately risk assessed and these were reviewed monthly to ensure their on-going usage was still required. Risks to people's care were identified, documented and staff knew how to support people's needs safely.

There were contingency plans in place to ensure peoples safety in the event of an untoward event such as accommodation loss due to fire or flood. Personal Emergency Evacuation Plans (PEEPs) had been completed for people living at the home. This provided an easy to follow guide for staff and emergency personnel about the support people required in the event of a fire. Staff knew the fire drill procedure and told us this was practised to confirm their understanding of the actions to take should the situation occur. In the event of an evacuation the provider would use another sister home in Aldershot and a day centre in Basingstoke to ensure people were kept safe. These plans allowed for people to continue receiving the care they required at the time it was needed.

There were sufficient staffing levels to meet people's needs. The registered manager identified that the staffing levels across the home consisted of three nurses, two assistant managers, 17 staff during the day with two nurses, one night care coordinator and eight care staff working during the night. The registered

manager was able to identify when additional staffing numbers were required. When people were receiving end of life care or required additional support as a result of their deteriorating health needs we could see that additional staff were used appropriately. Records and observations during the inspection showed the deployment of sufficient numbers of staff to meet people's care needs safely. Where shortfalls in the rotas had been identified these had been covered by existing staff and the use of agency staff. The registered manager tried to ensure consistency of care by using a regular pool of agency staff and known agency staff were requested in order to provide a familiar face to those receiving care. A member of staff told us, "On the very odd occasions that someone is off sick you might have a couple of hours before you can find someone but yes we have enough staff. It was always agency staff when I started where now it's all permanent staff, it's really good". Another member of staff told us, "We can ask (for staff) from different floors, we can borrow staff, it's about team work". People told us that they were receiving care when they required, one person told us, "(staff are) Always there and help if needed". Another person said, "Yes, there is always someone around".

Robust recruitment procedures were followed to ensure staff employed had the appropriate experience and were of suitable character to support people safely. Staff had undergone detailed recruitment checks as part of their application and these were documented. These records included evidence that pre-employment checks had been made including 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 who may be unsuitable to work with people who use care services. People were kept safe as they were supported by staff who had been assessed as suitable for the role.

Since our last inspection in December 2014 found that the improvements had been made relating to the guidance provided to ensure people received medicines prescribed 'As required'. 'As required' medicines include pain killers people can take when experiencing an increase of pain due to their medical or health condition. Guidance about why, when and how these 'as required' medicines should be administered to the individual were available with people's Medicines Administration Records (MARs). Protocols were in place to support staff to know when to administer these medicines to individual patients and MARs for these medicines were completely and accurately recorded.

People living at the home received their medicines safely. Nurses and care staff received additional training in medicines management and records showed that medicine administration records were correctly completed to identify that people received their medicines as prescribed. Nurses and care staff were also subject to annual competency assessments to ensure medicines were managed and administered safely. There were policies and procedures in place to support nurses and care staff to ensure medicines were managed in accordance with current regulations and guidance. Medicines were stored, administered and disposed of correctly which included those which require refrigeration to remain safe. 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. Controlled drugs stocks were audited and documented weekly by the registered manager, to check that records and stock levels were correct.

Requires Improvement

Is the service effective?

Our findings

People and their relatives we spoke with were positive about the ability of staff to meet their care needs. People said that they felt staff had sufficient knowledge and skills to deliver care. One person we spoke with told us, "Staff seem to be very knowledgeable". One relative told us that staff were aware of their mothers specific healthcare needs, "They (staff) know how to treat her".

People and relatives were mostly complimentary about the food provided. One person told us, "Food is very good, there is a good variety and it's always made for me", another person said, "(the food) Is very good… good choices, plenty to drink.. Fruit in the dining area but drinks and biscuits brought round often". A relative told us about the food provided, "When she (Family member) was better she wouldn't eat much so the carers would leave out finger food for her".

During mealtimes people were not always consistently supported to enjoy their meals at the time and pace appropriate to their needs. Observations in the discharge to assess unit and one of the residential areas of the home showed that lunch was unhurried, relaxed and staff were supporting people to eat at an appropriate pace for their needs. Meal times were a friendly, relaxed and sociable experience.

However this was not repeated throughout the home. On one of the residential units and one of the nursing units we found that staff were not able to meet people's needs in a timely fashion. People were being assisted into the dining room for 12:30hrs however lunch was not served until almost an hour later with some people still eating nearly two hours after the start of the allotted lunchtime service.

During a lunchtime sitting in the nursing unit three people were being supported initially by one member of staff to eat, one of these people required hand over hand support to eat whilst the others required continual prompting and encouragement. Hand over hand support allows people to be partly independent as staff guide people's hands from their plate to their mouths enabling them to eat. Another member of staff was requested to help encourage people to eat and to assist them with eating their meals however it took 20 minutes before another member of staff was able to assist. Regular temperature checks were being conducted on meals at the point of delivery to ensure it had been cooked to the appropriate temperature to kill harmful bacteria however would have cooled in the time it took for assistance to be provided.

This was brought to registered manager's attention who was already aware that lunchtime services could be slow. As a result of this identified need, prior to the inspection, the registered manager had recruited additional staff to act as general assistants. These general assistants would then be available to assist with the mealtime services. The first of these staff were due to commence their induction the week following the inspection. The recruitment and availability of additional staff to assist lunchtimes would ensure that people received the support they required in a timely fashion. Appropriate action had been taken to ensure that people's needs were being met but the registered manager needed more time to induct and train the new staff to ensure that the improvement in mealtime delivery were sustained.

People who were being supported in their rooms to eat were provided with focused one to one support and

encouraged to drink and eat to maintain their hydration and nutritional needs. Squashes were available in people's rooms with snacks available in dining areas to assist people to eat and drink sufficiently to ensure their on-going health and wellbeing.

The chef was aware of people who had specific dietary needs such as diabetic or those who required a pureed or soft diet. We could see that care had been taken when presenting pureed food so that it retained an appetising visual appeal and was separated on the plates to allow people to identify what they were eating.

The home had recently been redecorated and specifically designed for those living with dementia to enable them to live as independently as possible. The corridors in the living areas were wide, naturally lit, where possible, and very bright overall. The handrails were a contrasting colour to the walls which allows people with limited eyesight associated with old age and those living with dementia to identify a focal point to hold on to. Toilets and bathroom doors had additional pictorial signage to make identification easier for people with destination points at the ends of corridors such as; seating and views for people to spend their time. The carpet and flooring was appropriate for those with limited sight needs in neutral colours. Changing colours and patterns of flooring can be disorientating for those who have limited visual capacity as a result of their dementia. Each unit had a particular theme such as Bluebell and Primrose and we could see that colours were used to good effect to assist orientating people to their living areas. There were items available for use around the home which included memory stations such as a music station which had musical instruments for people to pick up however these were not very well sign posted and were found simply by looking around the wide corridor areas. The home was decorated to the residents' tastes and rooms were personalised with photographs, furniture, pictures and ornaments where wanted.

People were assisted by staff who received a thorough and effective induction into their role. This induction had included a period of shadowing experienced staff to ensure that they were competent and confident before supporting people. Staff had undergone training in areas such as, moving and handling, dementia awareness, safeguarding vulnerable adults, infection control and emergency first aid. Nurses had also undergone additional training on diabetes and wound care, holistic assessment, the use of a syringe driver (used to deliver pain relief in people's end of life stages) and tissue viability. Staff told us of the training, "The training is really good, they really go into detail about what they're teaching us", another member of staff said, "The training here is just amazing we get loads and loads of training here".

Staff were also encouraged and enabled to ask for additional training in areas that interested them although those spoken with had not yet done so. Staff were also motivated to further their own knowledge and development for the benefits of the people living in the home. One member of staff told us about an additional Dementia training course they had undertaken at a local college. This member of staff spoke about the positive impact their learning had on people. They provided detailed knowledge of dementia care and how activities could be used to good affect for people. They encouraged people to participate in jobs in the unit where they lived including washing up, making the beds and folding the towels. This had resulted in a positive change in behaviour in particular for one person living in the home who was more relaxed as a result of their interaction and able to remember the staff members name which they had not been able to recall previously. This member of staff had shared their knowledge and learning encouraging other members of staff to participate in the course to increase their understanding of the behaviours of those people living with dementia.

People were assisted by care staff who received support in their role. There were documented processes in place to supervise and appraise all care staff to ensure they were meeting the requirements of their role. The provider's policy stated that all employees were to receive a minimum of six formal supervision sessions a

year. Supervisions and appraisals are processes which offer support, assurance and learning to help care staff develop in their role. Staff told us and records confirmed supervisions occurred every two to three months. These supervisions took place in a variety of methods including group supervisions, observations of people's working and face to face meetings. Staff told us they were able to speak to their team leader, colleagues and 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's freedom was not unlawfully restricted without the appropriate authorisation being sought. 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 (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. The registered manager showed a comprehensive understanding of the DoLS which was evidenced through conversations and the appropriately submitted applications and authorisations. Staff spoken with understood why DoLS were required.

Staff were able to describe when a best interest decision would be most appropriate. Best interest decisions are made when someone no longer has the capacity to make a specific decision about their life. Records showed that the care plans were in the process of being updated to ensure that appropriate mental capacity assessments and accompanying decision specific best interest decisions were made in relation to each aspect of people's personal care and wellbeing. We could see that overarching assessments of capacity had previously been taken regarding people's care. This had been as a result of concerns raised by a healthcare professional who did not always feel that appropriate decision specific assessments were being undertaken. We could see that care plans had and were being updated to ensure that each aspect of a person's ability to consent to and receive their care was subject to a mental capacity assessment with appropriate best interest decisions in place. We saw that best interest meetings had been held for people when they no longer had the capacity to agree to a certain course of action involving their care. This included documenting and recording decisions that people had verbally agreed or a best interest decision had been made. This included the use of bed rails for those who were being nursed in bed. Consent to care and care plans were agreed with the person's relative or nominated person such as those with a Power of Attorney (POA). A person who has been provided with POA is there to make decisions for people when they are unable to do so for themselves

People were supported to maintain good health and could access health care services when needed. Processes were in place to ensure that early detection of illness could be identified. Some people living at the home required regular weighing as they were at risk of losing weight due to poor nutritional input. Records showed people had minimal variations in weight suggesting they were supported to eat and drink sufficient amounts to maintain a healthy weight. Professional health care advice was sought and followed by staff which was evidenced during the interactions with the staff. For example where people had difficulty eating or swallowing, a speech and language therapist's assessments had been requested and completed. One assessment requested that a specific thickener was used in a person's drink to prevent them from choking. The nurse confirmed the correct thickener which was being used to support this person and we

could see it was being used during the course of the inspection. There was evidence of referral to and collaborative working with healthcare professionals, families, people and staff.

Specific and clear guidance was provided to support staff on how to manage people living with certain illness or injury for example those pressure ulcers. We could see that people had moved to the home suffering from pressure ulcers. Care plans provided detailed advice and showed regular healthcare professional input had been provided to ensure that these were managed effectively and we could see that significant improvements had been made in people's skin conditions as a result.

Good

Is the service caring?

Our findings

Relatives and people told us that support was delivered by caring staff. One person we spoke with told us, "Yes (staff) are caring and patient…they are very good and kind". Another person told us about the staff, "They are very caring people". A relative told us, "They (staff) are incredibly so, very gentle with her (family member)…when she sees anyone she smiles". A healthcare professional said, 'I have observed staff demonstrate a good understanding of their resident's needs and preferences and deliver care to a high standard, maintaining dignity and privacy'.

Positive and caring relationships with people had been developed by staff. 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 food preferences, how people wished to be addressed and what help they required to support them. People's care plans also included 'What those who know about me say they like and admire about me'. This was a very personal list of personality attributes that people wanted others to know about them. This included one person who wanted people to know that they were very caring and helpful who would stand up against things which are unfair or unjust. This was a very person centred way of telling staff about the personality traits of people prior to their diagnosis of dementia helping provide a detailed, thorough and personal knowledge of people. 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. People were treated with dignity as staff spoke to them at a pace which was appropriate to their level of communication. Staff allowed people time to process what was being discussed and gave them to respond appropriately. All the staff we spoke with told us the reason they most liked working at the home was caring for the residents. One member of staff said, "The residents are lovely…I enjoy (working at Oakridge) and I enjoy coming in here". Another member of staff told us about their role, "I find the job very rewarding, I go home thinking I've helped these people today and I get satisfaction from that". Whilst staff were busy they continued to treat people with respect and showed a genuine care for people's wellbeing.

People who were distressed or upset were supported by staff who could recognise and respond appropriately to their needs. Staff knew how to comfort people who were in distress. Some people living at the home experienced mood changes associated with their mental health conditions. Staff were able to evidence in detail that they knew how to support people and recognise when people were at risk of suffering a period of low mood. This included identifying the physical symptoms that people would exhibit such as withdrawing from a previously active social life or displaying a general low mood. All the staff we spoke with were able to describe how they would support people in a caring way and raise their concerns to the nurses when they were worried someone was exhibiting signs of depression. Where appropriate physical contact was used as a way of offering reassurance to people when in distress. We saw that staff held hands with people and used touch support to interact with people to engage with them. When people became distressed staff were able to discuss the benefits of offering a cuddle, massage or distraction by telling people something funny from their own personal lives. Staff told us that in cases where people were distressed they were able to seek support from other staff members to ensure that they had the

uninterrupted time to provide emotional comfort.

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.

People were treated with respect and had their privacy maintained at all times. Care plans and associated risk assessments were kept securely in the nursing stations 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 that people were suitable clothed and had their modesty protected when they were assisted with their personal care to and from the bathrooms and toilet. People were provided with personal care with the doors shut and curtains drawn to protect their privacy. Staff were seen to ask people before delivering or supporting with the delivery of care. People told us that staff were respectful through their interactions with them, one person told us, "They (staff) respect my privacy and listen to what I have to say". Another person said, "Yes (I'm) definitely treated with dignity and respect".

People were also respected by having their appearance maintained. Attention to appearance was important to people and noted in care plans. Staff assisted people to ensure they were well dressed, clean and offered compliments on how they looked.

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, their wishes about where they wanted to be and what surroundings and people they wanted present at the end of their life. People receiving end of life care were being appropriately supported by staff using the 'Thinking ahead' approach which is part of a gold standards framework for advance care planning. Advance care planning is a structured discussion with people and their families about their wishes and thoughts for the future. Advance care planning is a key means of improving care for people nearing the end of their life and enabling better planning provision of care, to help them die in a place and the manner of their choosing. Evidence showed that people receiving end of life care were doing so with all the appropriate support from staff and healthcare professionals with their end of life wishes being respected.

Requires Improvement

Is the service responsive?

Our findings

Where possible people were engaged in creating their care plans. People not able to or unwilling to engage in creating their care plans had nominated friends and relatives who contributed to the assessment and the planning of the care provided. One relative told us, "I am involved in her (family member's) care plan". A healthcare professional told us, "Resident's and those important to them are more involved in the care planning process and I often see nurses discussing and reviewing plans of care with residents and their families either face to face or on the phone. I have witnessed some good and supportive conversations between residents and those important to them about plans for care and treatment".

People's care needs had been assessed and documented by the nursing or managerial staff before they started receiving care. These assessments were undertaken to identify people's support needs and develop care plans 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 these reviews to ensure people received personalised care. One relative told us in relation to creating their family members care plan, "I have a Lasting Power of Attorney (for their family member) they (staff) talk and listen to me". When identified that there had been a change in people's health care needs or people requested action to be taken on their behalf this was recorded and actioned appropriately. Records showed a person had requested a Do Not Attempt Cardiopulmonary Resuscitation to be completed on their behalf during a care plan review. This request was recorded, completed and the person's care plan updated accordingly. People were receiving care which was reviewed regularly to ensure it remained relevant to their needs.

Relatives with the relevant Power of Attorney (POA) to assist in the decision making process were informed when reviews were happening to ensure their views could be taken into consideration. A person with a POA has the legal authority to make decisions on people's behalf. When identified that there had been a change in people's health care needs or people requested action to be taken on their behalf this was recorded and actioned appropriately. When healthcare professional advice had been sought the information provided had been used to update people's care plans accordingly.

Handover between staff were held on each floor in each unit. These were held between the nurses and the care staff. The handover contained specific and detailed information in relation to people's needs such as their health diagnosis and information about changes in people's moods. They also included whether there had been any incidents of illnesses such as vomiting that staff should be aware of to monitor appropriately. We observed a handover and noted staff evidenced a detailed knowledge of the people they were supporting such as talking about people's individual preferences for a male or female member of care staff to support them with their personal care. The handover also included information regarding the activities available for people to participate in and those who would be willing to attend. People were supported by staff who knew their health needs and ensured that all members of staff responsible for their care were aware of any changes in the physical or mental wellbeing.

The provider sought to engage people in meaningful activities but there were not always sufficient activity

staff hours to allow for personalised interaction on a one to one basis for those receiving support in their rooms. However where activities staff were not always able to visit people in their rooms care staff recognised the need for people to receive social interaction to prevent them from suffering from isolation. One member of staff told us, "I did someone's nails yesterday and hand massage so we do what we can, sit and have a cup of tea and watch TV (with them)". Another member of staff provided an example where they had identified two people who did not wish to participate in group activities but enjoyed conversation. As a result she was able to introduce both people and they were able to participate in regular social interaction.

Whilst there were insufficient numbers of activities staff available to meet everybody's individual needs other staff were aware of the need of interaction to prevent people suffering from social isolation. The registered manager was aware of the need for people to receive personalised interaction when they did not wish to or could not participate in group activities and was in the process of taking action to address. The deputy manager discussed the use of a sensory machine which would be used to emit smells and project images which would provide care staff with additional resources to assist people supported in their rooms. The provider was also in the process of finalising the building of a bar adjacent to the main dining room area. This was to be opened in time to celebrate the Queen's birthday. When operational it was hoped that this would act as a focal point for residents and provide a welcoming atmosphere for everyone at the home. This was also being developed as a way of providing more male specific activities to encourage their participation in social activities in the home. The registered manager was aware of the importance of reducing people's risk of social isolation and was taking steps to address these concerns but needed more time to fully implement these actions to ensure that they were successful and sustained.

A typical week activities rota was viewed which had defined activities from Monday through to Friday. This included a salon morning, shake along (an exercise class involving musical instruments people were encouraged to use), gardening, pastoral visits, cross words, ball games, film shows and one to ones with people in their rooms. External organised activities were not regularly included in the activities programme, a lack of available transport for use by the home meant that this was not always possible for people. Utilising local transport links people were encouraged at Christmas to visit Christmas shows and visit local schools to participate in their school party. Internal larger organised activities included professional musicians performing in the home, Christmas shows and singing groups. Where people were more mobile they were encouraged to go with staff into town using public transport to participate in shopping trips and to enjoy a cup of coffee at a local café. We could see that this activity was being supported by staff during the inspection.

People 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. The provider's complaints leaflets were available in the homes lounges which was accessible to visitors and relatives. This listed where and how people could complain and included details of how to complain in alternative formats such as by telephone, in writing, online and in fax. The provider's complaints policy included information on how to raise concerns with the Local Government Ombudsmen if the complainant remained dissatisfied with the outcome of their complaint. It also included website contact details for the complaints and customer care team, department of health, the information commissioner, the LGO, the Care Quality Commission and the office of Public Sector Information.

Complaints made in writing and verbally received were documented and recorded in a complaints folder in the registered manager's office. A selection of complaints were viewed. Where appropriate complaints had been referred to other external agencies such as the Police and safeguarding teams to investigate. Records showed that the complaints were shared with the correct external agencies and joint working had ensured that the cause of complaints were resolved. We saw that the complaints raised were investigated by the

registered manager and steps taken to address the causes of the complaints. The complainants were then responded to appropriately in accordance with the provider's policy.

Good

Is the service well-led?

Our findings

The registered manager promoted an open, friendly and supportive culture at Oakridge and actively support feedback from people living at the home, their friends and family. Most people we spoke with were confident in the registered manager's ability to manage the service and address concerns. People and relatives told us they were happy with the quality of the service provided. One person told us, "(the home is) Beautifully run, staff are very hands on". Another person told us, "I don't know who the manager is but the staff look after me. The atmosphere is very good". A relative told us, "Yes (the home) is very well run, management are helpful and easy to speak to".

A healthcare professional told us they found the assistant deputy manager had 'An intuitive, person centred approach to care and desire to support residents to maintain their maximum independence, balancing the risks against the benefits. His vision is to improve the environment so that it is more dementia friendly and improve opportunities for meaningful and person centred occupation for his residents'. This was in regards to the undertaking of a specialised piece of work surrounding the use of prescribed medication to support people living with dementia. This piece of work had only just commenced but would eventually be used to support those to manage their conditions without the use of medication and consequent negative side effects.

The registered manager was keen to promote an open and happy culture amongst people, staff, relatives and visitors. This aim was underpinned by providing a comfortable homely environment where care was delivered to support people to live their lives as they did prior to receiving care. This was understood by staff and promoted. A compliment was viewed which read, 'Something's are felt rather than seen, Oakridge House is a family and we feel very much part of that too'.

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 how important these values were. One member of staff told us, "(the registered manager) wants everyone to be treated with dignity, respect and kindness and I would say how you would treat your own parents". Another member of staff said, "(the registered manager says) the way we would want to be treated, with respect and dignity". A relative told us that all staff were open to listening to them "Yes I do (think the home is well led), it's like a family. We all get together and chat. It's very friendly and I would certainly recommend it. The manager is always accessible if needed". This caring culture was reinforced with staff through supervisions and appraisals, training and observations conducted by the registered manager around the home.

The registered manager was a visible presence to people, relatives, visitors and staff. Staff were positive about the registered manager and the support they received to do their jobs. They told us that the registered manager was open to their concerns and needs. One member of staff told us, "We're open here…we have a

happy home we do support each other, you can talk to (management) about anything be it personal and you can always speak to the registered manager and it's being treated confidentially, it's a relief and reassuring that it's always there".

The registered manager sought to make themselves visible by completing a walk of the home on a daily basis. This was in order to see if there were sufficient levels of staffing to meet people's needs and to interact with people and staff visiting the home. The registered manager was keen to ensure that people living, working and visiting the home were aware that her door was always open and she was available to speak with people as and when they wanted. One relative told us, "Both myself and my daughter think the management and the facility is excellent, they keep me informed at all times and you can always talk with them. They always greet me by name and have time to chat."

The registered manager was able to evidence that they knew what was required of their role. 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 to ensure they respond 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.

The quality of the service people experienced was monitored through regular care plan reviews, residents and relatives surveys and meetings. The minutes for the last three residents and relatives meetings were viewed which documented that people were kept informed regarding the activity programmes on offer, updates on decoration plans for the home and recruitment. These were also used as an opportunity to request feedback on the quality of the service delivered including the food and menu choices on offer. During these meetings when feedback was provided this was listed and acted upon. During a meeting in April 2016 it was requested that there could be more cups of tea, snacks, cakes and biscuits available to people. This was being addressed by the registered manager who was in the process of identifying a 'snack station' that would be available in public areas allowing people and their visitors to help themselves to additional snacks. The provider also used a post box in the foyer area which allowed people to anonymously, if wished, raise their concerns or offer feedback on any aspect of care delivery or management of the home. One of these were viewed from January 2016 where it made the suggestion that it would be useful for guests to be able to access the internet whilst visiting. The manager responded to this person by letter thanking them for their comments and implemented a system where the administrative staff would place the internet details and password in the foyer.

The provider also sent questionnaires to people and their relatives requesting feedback and asking them to rate the home in areas including, the range of activities, staff attitudes and the food available. The last survey was completed in December 2015 and the results were publically available to people and included actions that were going to be taken to address their concerns. During the survey some people stated they wanted to get into the lounges and gardens more often. As a result the garden was re-modelled with raised beds and features to make it more attractive. The results of this survey were also used to create the bar area which was going to give residents more opportunities to socialise. The provider actively sought feedback from people and used this as a way to improve the quality of the service provided.

The provider also completed a number of quality assurance audits at the home to monitor the service provision. Audits were required to be completed on a daily, monthly and bi-monthly audit by the provider. These gathered evidence of compliance with the regulations from a range of sources which included audits of care plans, infection control audits and medication management audits.

When these audits identified areas for improvement the actions were recorded and monitored for

completion to ensure that the home was meeting the identified standards and evidence this had been completed. The last audit, conducted by the operations manager in March 2016 identified that staff needed additional training on reablement. This is specific training which provides guidance to staff on how to actively enable people to regain and maintain their independence. This is of particular importance in the discharge to assess unit. We could see that this training was in the process of being sourced for staff. The Improvement log was viewed and we could see that when actions were identified they had been addressed in a timely fashion with appropriate evidence provided to identify the service had improved. A survey in March 2016 identified that new mental capacity forms needed to be completed for all residents. During this inspection we could see that this work had already begun and decision specific forms were being completed for each individual part of people's care plans. This meant that people were appropriately assessed to ensure that they could make more specific decisions regarding each aspect of their care delivery. The provider and registered manager had audits in place which were used effectively to identify areas where improvements could be made to the quality of the service provided.

People, their relatives and visitors spoke positively of the quality of the care provided. Relatives told us they had a good degree of satisfaction with the home. Written compliments had been received by the home thanking them for the quality of the care provided. One relative spoke very highly of the quality of the care provided to their family member whilst at Oakridge House. This relative had written 'I am writing to you because excellence in the provision of a service should be recognised and supported when it is delivered,… the care facility is very well designed, arranged and run and the staff (everyone we met) are professional caring and friendly.' They continued to discuss the positive change experienced in their family member's health whilst living at Oakridge. This person continued, 'The balance between getting the job done and dealing with sensitive elderly people was excellent and we cannot praise the team strongly enough'. Staff identified what they felt was high quality care and knew the importance of their role to deliver this. Staff were motivated to treat people as individuals and deliver care in the way people requested and required. We saw interactions between the registered manager, staff and people were friendly and informal. People were assisted by staff who were able to recognise the traits of good quality care and ensured these were followed.