Keenglen Care Homes Limited

Silver Oaks Residential Care Home

Inspection report

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Date of inspection visit:
24 April 2018

Date of publication:
25 June 2018

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

This inspection took place on 24 April 2018 and was unannounced.

Silver Oaks Residential Care Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. The home provides single bedrooms for up to 19 older people over two floors, accessed by stair lifts. At the time of our inspection there were 19 people using the service, some of whom were living with dementia.

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.

At our last inspection in November 2015, we rated the service overall as good. At this inspection we found the evidence continued to support the rating of good. There was no evidence or information from our inspection and on-going monitoring that demonstrated serious risks or concerns. This inspection report is written in a shorter format because our overall rating of the service has not changed since our last inspection.

People remained safe using the service. Staff had been trained in safeguarding people and understood how to assess, monitor and manage the risks people faced. People were protected by safe recruitment procedures to help ensure staff were suitable to work in care services. There were enough staff to meet people's needs.

The provider had made improvements to ensure people's medicines were managed safely. Medicines were stored, given to people as prescribed and records managed safely. Staff received medicines training and understood the importance of safe administration and management of medicines.

People continued to receive care from staff who had the skills and knowledge required to effectively support them. Staff completed a range of training relevant to the needs of people using the service and were supported to undertake further development training to enhance their skills and knowledge in areas of interest.

People's human rights were protected because the registered manager and staff had an understanding of the Mental Capacity Act 2005 (MCA) and their responsibilities within the legislation. People were supported to have maximum choice and control of their lives. Staff supported them in the least restrictive way.

People's health and well-being needs were assessed and met by staff who responded effectively to people's changing needs. The service worked closely with health and other professionals to ensure they met people's

health and well-being needs. People were supported to have good nutrition.

People continued to receive a service that was caring. Staff showed kindness, patience and compassion for people through their conversations and interactions. Staff supported people to communicate in the way they preferred. Staff enabled people to maintain their independence as much as possible. People's privacy and dignity were promoted at all times.

The service remained responsive to people's individual needs and provided personalised care and support. People were able to make choices about their day to day lives, including how they spent their time. The provider had a complaints policy in place and records confirmed any complaints received were fully investigated and responded to.

People received good care from a well-led service. People used a service where the provider's person-centred values were embedded into the leadership and governance, management, staff working practices and culture of the service. The registered manager was experienced and took the time to listen and responded to people, staff and others.

The provider had systems in place to monitor, assess and improve the service. There was an open, transparent culture. Staff were positive and happy as a team and in their roles. People, staff and others were supported to share their views and these were used to drive improvements within the service.

Further information is in the detailed findings below.

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 has improved to Good.

This was because the provider had made improvements to the administration and storage of medicines to ensure people received their medicines safely.

Is the service effective?

Good

The service remains effective.

Is the service caring?

Good

The service remains caring.

Is the service responsive?

Good

The service remains responsive.

Is the service well-led?

Good

The service remains well-led.

Silver Oaks Residential Care Home

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 checked 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 24 April 2018 and was unannounced. The inspection was carried out by one inspector and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before our inspection we reviewed the information we held about the service. This included notifications of incidents that the provider has sent us since our last inspection. A notification is information about important events and incidents within the service which the provider is required to send us by law. We also spoke with commissioners, responsible for funding some of the people using the service, to gain their view of the care provided.

The provider had not been sent a Provider Information Return (PIR). This is information we ask providers to complete to give some key information about the service, what the service does well and improvements they plan to make. We gave the registered manager the opportunity to provide this information during the inspection.

During our inspection we spoke with nine people who used the service and two visitors. We also spoke with the registered manager, the deputy manager, four care staff, the activities co-ordinator and the cook. We observed care and support provided in communal areas and the lunchtime meal. This helped us to evaluate the quality of interactions and support that took place between people and staff.

We reviewed information including care plans and records for three people, medicine records, three staff

recruitment and training records, records relating to the day-to-day management of the service and the provider's audits and quality management systems.

Good

Is the service safe?

Our findings

The service continued to keep people, visitors and staff as safe from harm as possible. One person told us, "I had a lot of falls at home before I came here, but I haven't had any since getting here. I think just knowing that there is someone there for you, whatever time of day it is, makes you relax and stop worrying about falling." Another person told us, "The staff are very good here. They soon spot if there is anything different about me and chat to me to make sure I am okay." Visitors told us, "We can honestly say that [name] would have been dead now if [name] had not come to live here. [Name] is safe and seems very happy."

At our last inspection in November 2015, we rated the Safe domain as Requires Improvement, This was because systems for the administration and management of medicines was not always safe. At this inspection we found that improvements had been made and people's medicines were well managed. Medicines were administered by senior care staff who had received the relevant training to safely administer medicines. Training records showed this training was regularly updated. Medicines administration records we reviewed had been completed accurately.

Each person's medicines were stored securely in their rooms, with the exception of medicines that required specific storage. People's medicine plans provided staff with guidance on people's medicines, possible side effects, allergies and how they liked to take their medicines. We saw staff followed these medicines plans when they supported people to take their medicines. Medicines guidelines for people who received medicines on a 'when required' basis (PRN) were in place, for example, for pain relief.

Two people received their medicines covertly, hidden in food or drink. Although authorisations from an appropriate health professional were in place, these did not provide staff with the guidance they needed to administer the medicines safely. For instance, the protocols did not advise in which food or drinks the medicines could be administered or which to avoid. The registered manager told us they would obtain this information from the GP and include in the protocols.

Medicines not stored in people's rooms were stored safely and temperatures of these areas were monitored. We saw records which showed that although temperatures were within recommended limits to maintain the condition of medicines, there were gaps in recordings which meant temperatures were not checked daily. The registered manager told us they would ensure staff recorded daily temperature checks following our inspection.

People were protected, as far as possible, from any form of abuse. Staff were trained in protecting people from abuse and had the knowledge and understanding of their responsibilities to identify and report any concerns relating to abuse of people. There were systems for recording and reporting safeguarding concerns. The registered manager investigated and took appropriate action where concerns were raised, including informing external agencies to ensure timely and effective action was taken to keep people safe. The provider's safeguarding policy was available for people and visitors on notice boards in communal areas. However, it did not include contact details of relevant local agencies to support people to raise concerns outside the service. The registered manager told us they would ensure these details were included

with the policy.

People were protected from risks to their health and wellbeing because staff were provided with written assessments about the risks people faced and how to mitigate them. Where people required support to move around the service, equipment to be used was clearly detailed together with the number of staff required to provide the support. Risk assessments identified specific risks for each person and provided staff with clear and detailed guidance and direction on how the person should be supported. For example care plans for supporting people at risk of developing pressure ulcers guided staff about how to support the person to prevent these.

We observed staff supported people safely. For instance, where one person was using a walking aid, the staff member supporting them gently reminded them not to over-stretch and to walk into the frame to prevent them losing their balance. They used encouragement and praise to support the person in using the aid. We saw another staff member supporting a person to transfer from a stair-lift. The staff member provided reassurance and consulted with the person throughout, ensuring they wore a safety belt whilst using the stair-lift to ensure they were safe whilst using the equipment.

There were effective risk assessments to support people whose behaviour may challenge the service. People's care plans identified possible triggers that may lead to the behaviour and what staff should do to support people who had become distressed. For instance, one person could become verbally and physically agitated. Their care plan guided staff on appropriate intervention, which included touch and specific distraction techniques. Staff worked with health professionals to support people and staff on appropriate intervention and reviewed if behaviour management strategies were effective.

People had their finances looked after safely by family members or appointees. People were provided with secure storage to keep their monies and valuables safe. Where staff supported people to spend their money, records of expenditure were maintained and made available to family members and appointees for regular checking.

People were supported by sufficient staff to meet their needs and this was confirmed by people and staff who we spoke with. We observed staff were attentive to people's needs and people did not have to wait long if they needed assistance. Staffing rotas we reviewed showed the staffing levels we observed were the usual ones. Staff responded to cover planned and un-planned absence which meant people received care from a consistent group of staff who were familiar with their needs. Senior staff and the registered manager provided management support outside of normal working hours.

All areas of the service were clean and free from offensive odours. Staff demonstrated they understood and worked within best practice to control the risk of infection for people. For example, we observed staff wearing appropriate personal protective equipment, such as gloves and aprons, using hand sanitizers and washing hands after tasks. The provider's infection control policy supported staff to wear items of clothing and jewellery in line with their cultural beliefs, whilst also advising on adapting these to ensure staff complied with safe infection control.

Incidents and accidents were monitored and actions were taken to prevent the problems occurring again. For example, falls were monitored and analysed each month to identify trends and patterns. For one person, this had resulted in additional equipment being placed in their room to reduce the risk of falling and sustaining injuries. The provider worked hard to learn from mistakes and incidents to ensure people were safe. They had improved security for people by installing secure storage for valuables and CCTV in communal areas. The provider had consulted with people and their relatives in an open and transparent

way, in line with the Duty of Candour. The Duty of Candour is a legal obligation to act in an open and transparent way in relation to care and treatment.

Good

Is the service effective?

Our findings

The service continued to provide people with effective care and support. People received care from a regular team of staff who had good knowledge of the people they supported. Staff demonstrated they were confident and competent in their roles which meant they understood and were able to meet people's needs.

People's needs were assessed prior to them using the service. Assessments included people's personal preferences, their social interests, cultural and spiritual wishes, as well as physical and emotional needs. People and relatives told us that staff understood their needs and wishes and provided care in line with their preferences. Visitors we spoke with told us, "They [staff] have quickly got to know [name] likes and dislikes. [Name] is eating better than [name] has in a long time and we don't have to worry anymore."

People were supported by staff who received regular updated training. Staff told us training was provided in areas which were relevant to people who used the service. Staff were positive about the training they undertook. Comments included, "We get good training and can ask if there is something else we want to study which helps us give a better all-round service, "We complete a combination of e-learning and face-to-face training. The [registered] manager supports us to undertake further training in our areas of interest. I have completed lots of training in dementia care," and "The training is good. We can do the e-learning at home if we wish. I have recently completed training in mental capacity which was really interesting and helped me understand people's rights and my responsibilities to uphold them. I am studying towards further development training, which is encouraged by the [registered] manager."

Records confirmed staff were provided with a range of training and this was regularly updated. The registered manager had recently updated the induction programme for new staff which supported them to learn about people's needs and gain confidence in their role before they began to support people. Two staff had completed the Care Certificate. The Care Certificate is a recognised qualification that ensures that staff have the fundamental knowledge and skills required to work in a care setting.

Staff received regular supervision and support from managers. This included monitoring of their practice, formal and informal face-to-face supervisions, spot checks and competency checks. Staff confirmed the management had an open door policy, were supportive and encouraged staff to develop in their role and as individuals.

People's nutritional needs were met and any risks identified and managed. Staff knew what foods people liked and disliked and foods they were unable to eat; they understood the importance of good food for people's wellbeing. One staff member told us, "I think presentation of food is really important. We eat with our eyes. I wouldn't give anything to a resident that I wouldn't eat myself. I have been speaking with residents about food that they remember as a child and then we have cooked it and spoken about the memories it evokes. I call it memory food."

People were positive about the support they received. Comments included, "The food is very good and very

tasty. You can tell it's home cooked, " "I haven't felt like eating much [due to poor health] but they [staff] offer me all sorts of nice things to try and tempt me to eat," "The food here is very good and there is plenty of fresh fruit available," and "I am a vegetarian and the cooks do a really good job of providing plenty of variety for me."

We observed the lunchtime meal to understand people's dining experience. We saw people were able to choose where they wished to eat and dining areas were set with tablecloths, flowers, condiments and serviettes. People were served meals based on their individual choices and supported to choose accompaniments. Where people required encouragement to enable them to eat, staff provided appropriate intervention and support. This included aids and adaptations, such as red plates (to support people living with sensory impairment or dementia) and plate guards, verbal and physical prompts and distraction. Staff played appropriate music in dining areas to create a calm ambience and people were supported to eat their meals at their own pace. This resulted in a positive dining experience for people.

People assessed as at risk from poor nutrition were monitored through regular checks and evaluation of their weights. Staff completed fluid and food intake charts and ensured people were provided with sufficient drinks throughout the day to prevent them becoming dehydrated.

Staff had developed effective working relationships with a variety of health care professionals to support people to maintain their health and wellbeing. Staff worked alongside people's GP, dieticians and psychologists to assess people's health and needs, and participated in regular reviews to ensure treatment was effective. People were supported to access routine health appointments, in addition to specialist healthcare. Summary care plans together with any specific health needs or requests were kept in people's rooms to accompany people in the event of emergency admission to hospital. The provider had installed a defibrillator in the service to support staff in the event a person required resuscitation.

The registered manager and staff understood their responsibilities in relation to the legislative framework, The Mental Capacity Act 2005 (MCA). The MCA provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When people lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and the least restrictive option available. The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

Where people lacked the capacity to understand the implication of decisions about their care, best interests decisions were taken with appropriate health professionals, an advocate and care staff who knew them well. Care plans included an assessment of people's mental capacity, the decisions they were able to make and the support they needed to make specific, more complex decisions. DoLS authorisations for people whose freedom was potentially restricted, for example due to locked doors or because they required constant supervision, were kept under review and new applications for authorisations made before current authorisations expired. We observed staff sought people's consent before providing care and support and records showed staff respected people's right to decline their care and treatment. Staff confirmed they had completed training in mental capacity and kept their knowledge up to date to ensure they were providing care in line with best practice.

Overall the premises were well maintained. The provider had made improvements to the premises which included converting a small lounge to a dining/snug area. This had attracted small groups of people to use the area as an alternative to the main dining area. Communal areas were furnished with objects of reference and appropriate furniture for people. This included external areas where staff had created a 'memory shed'

in the garden where people and visitors could sit, handle objects from bygone years and share memories. People's rooms were personalised, with each front door painted a different colour and rooms decorated and furnished to people's individual preference. People were supported to make their rooms homely by bringing in their own furniture and belongings. Staff had developed pictures depicting the person's interests, such as gardening or animals, and these were available outside people's rooms to support personalised care.

We recommended the provider review a small area of uneven flooring on the first floor landing and access to the staircase from the first floor to ensure these areas were safe for people using the service.

Good

Is the service caring?

Our findings

People continued to receive a service that was caring. People were positive about the staff who provided their care. Comments included, "The staff are all lovely here, not a bad one amongst them. They are kind and gentle. They know me well and nothing is too much trouble for them," "The staff are very good here," "I know the [registered] manager, she is lovely. They [staff] all are. I am very happy here," and "The staff are discreet and respectful" (person explained particularly when staff were supporting them with personal care).

We saw staff used appropriate humour, banter and physical touch to communicate with and comfort people as necessary. Care plans included information about the person such as, "This is me". This document provided details about the person, their wishes and preferences and their life history and included how they preferred to communicate. This helped staff to ensure they supported and respected people's individual needs.

The registered manager had made 'flash cards' available in communal areas around the service. These were cards containing a picture or symbol which staff used to communicate with people who were unable to understand complex verbal communication. A range of information was available on communal notice boards, advising people and visitors on how to raise complaints, concerns about safeguarding and access to advocacy services. This helped to ensure people were able to express their views and be involved in their care.

Staff involved people's representatives and friends in their where this was appropriate and agreed. People were encouraged to maintain contact and have relationships with those who were important to them. People's care plans included details of relevant and important family and friends that were involved in that person's life. One person told us, "My [relative] lives nearby and they [staff] keep him informed about my care and either they speak with me or he speaks to me about things I need to know about." People were allocated two 'key workers' from the staff team. These were staff members who co-ordinated the day-to-day aspects of the person's care and were available as a point of contact and information for relatives. Photographs and names of keyworkers were displayed by each person's room which helped relatives to identify the appropriate keyworker for their family member.

People were able to receive visitors whenever they wished and we observed staff were welcoming and attentive to visitors throughout our inspection. A visitor told us, "We can visit at any time, we are made to feel welcome." The registered manager had displayed names with photographs of all staff in the reception area to enable people and visitors to easily identify staff.

Staff told us they had the time and resources they needed to be caring. One staff member told us, "The [registered] manager and the owner are very person-centred and make time for people. This home offers a more intimate experience for people and I certainly enjoy working here."

Staff used language in people's care plans that was caring and respected people's privacy and dignity. Staff had undertaken training and some staff members were appointed dignity champions to support other staff

to promote and uphold people's dignity. We observed staff being respectful towards people. Signs were used outside people's rooms and bathrooms, informing staff to 'knock before entering' and 'do not disturb'. Staff were discreet when providing care and support.

People's independence was promoted and care plans guided staff to support people to be as independent as possible. For example, people were supported to be involved in household tasks. Staff did not rush people and offered support at each person's individual pace.

Good

Is the service responsive?

Our findings

The service continued to be responsive. People's needs were assessed prior to accessing the service to ensure their needs could be met. People told us staff understood them and were knowledgeable about their needs. Comments included, "They [staff] look after us well here and if we want anything, we only have to ask," "They [staff] asked me quite a lot of questions about my likes and dislikes when I first came here and I feel the staff know me well," "They [staff] seem to know what I need before I do sometimes," and "One of the carers sat with me and was chatting about my childhood. We had a good laugh remembering some of the things I used to get up to."

Care records contained details of people's personal histories, interests and preferences. For example, one person liked to have a specific soft toy in their bed to comfort them. We observed, when we visited the person in their room, staff had ensured the soft toy was in bed with the person and they took comfort from this. Care plans were written in a very person-centred style. People's diverse and changing needs were met by knowledgeable staff who were kept up to date with any changes in people's care. Handover of information at the start of each shift ensured updates to people's care was communicated to all staff. Records showed care plans were regularly reviewed and involved people, their relatives and health and social professionals where appropriate.

Discrimination was understood by the registered manager and the staff team. People were protected from discrimination by staff who had received training in equality and diversity. Staff were observed being sensitive to people and supporting them to meet their diverse needs.

People were supported to participate in activities if they wished. We saw people were provided with newspapers and objects of reference for stimulation where appropriate. During the afternoon, a staff member supported some people with pampering, which was nail care. Staff told us people responded well to going for walks around the village or to the local shops and organised day trips. A member of staff had recently taken on the responsibility of co-ordinating in-house activities for people. They were exploring activities that interested people, including memory boxes and re-starting yoga which had previously been provided.

People's care plans included communication guidelines. This included their preferred method of communication and receiving and responding to information. This helped to ensure people were supported within the principles of the Accessible Information Standard (AIS). AIS is a framework put in place from August 2016 making it a legal requirement for all providers to ensure people with a disability or sensory loss can access and understand information.

The provider had a complaints procedure which was accessible by people, their friends and families and others interested in the service. People told us they felt able to raise any concerns and were confident these would be dealt with in a timely manner. One person told us, "If I had a complaint, I would feel okay speaking with [name of staff] or [name of staff]. If they weren't around a carer would sort it out for me. I don't have anything to complain about though." Another person described how they raised a concern that a person

was wearing an item of their clothing. They told us staff resolved this discreetly and respectfully and to their satisfaction. Records showed complaints and concerns had been investigated in line with provider's procedure and outcomes provided in a timely manner. The registered manager had provided apologies where care had fallen short of expectations and informed complainants of improvements that had been made as a result of their complaint.

At the time of this inspection there were no people close to the end of their life. We found the registered manager and staff understood ways of ensuring people would receive appropriate care at the end of their lives, with dignity and as much independence as possible. Staff had completed training in end of life care and had worked in partnership with other agencies to support people who were closed to the end of their life prior to our inspection. This demonstrated people who needed end of life care could be confident their needs would be met.

Good

Is the service well-led?

Our findings

People continued to receive a service that was well-led. People were positive about the leadership of the service. Comments received included, "The owner is nice and comes here often to visit and brings his family. He knows our names," "I think they [staff] are a happy team here. They all just muck in and get the job done," " I am very, very comfortable living here. I am supported to really be myself," and "It's the next best thing to your own home here. Everyone is very friendly and all my family feel welcome when they visit."

Staff spoke highly of the registered manager and of the service. Comments included, "I feel supported by my manager, and the owner is a lovely person too," "They [managers] encourage you here. I can discuss any issues and the owner here is very person centred; which makes a big difference," and "Managers make time for service users' they don't shut themselves in the office. The [registered] manager spends time with people and staff."

The registered manager and the deputy manager were involved in the day to day delivery of care which meant that they had regular contact with people. They told us they used this as an opportunity to get feedback about the care that people received and ensure that people remained satisfied with the care they received.

The provider had a number of ways to listen to people's feedback about the service and the care provided. People and their friends, families and representatives views were recorded as part of quality satisfaction surveys and at monthly meetings. A comments book was available in the reception area to enable visitors to record their experience of the service. This information was analysed and recorded as part of developing the service. Any issues were acted upon. For example, where people had commented they were unsure about key policies and procedures; the provider had made these available in a format people could understand and provided copies on communal notice boards for ease of reference.

Staff meetings were held regularly and minutes were kept. We reviewed minutes of meeting held in April 2018 and saw these were used to review where improvements were needed in working practices, share information and discuss and resolve issues. Staff spoke about positive teamwork and respecting diversity within the staff team. One staff member told us, "I am not from the UK but everyone has made me feel welcome and involved." They told us staff respected each other as equal members of the staff team. Staff demonstrated they were committed to upholding the provider's values of providing person centred care within a homely environment.

The provider had systems in place to monitor, assess and improve the service. Checks and audits were carried out regularly on all areas of the service, including observations of staff working practices and competency. The provider had a governance framework which included audits and checks by a consultant to ensure the service achieved and maintained compliance. This helped to monitor the leadership of the service, as well as on-going quality and safety of the care people received. For example, there were processes in place to check accidents and incidents, environmental and care planning. This helped to promptly highlight when improvements were required.

The registered manager worked with the local authority commissioning team to ensure they met the local authority's required standards. They had a range of checks and audits in place to ensure they met all relevant legal requirements and good practice. Local authority commissioners, responsible for funding some of the people using the service, told us they had no concerns about the service

The registered manager and staff had established effective relationships with the external agencies and the local community. This included the local school where children visited people using the service which in turn facilitated understanding between people and the local children. The registered manager was exploring further opportunities where the service could engage with the school and their curriculum to involve people in activities and community life.

The registered manager and provider were aware of the legal responsibilities in notifying the CQC of significant events and incidents within the service. The provider had displayed their ratings in line with their legal requirements.