HC-One Limited

Oaklands (Nottingham)

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection took place on 21 June 2016 and was unannounced. Oaklands Care Home is a 40 bedded home and at the time of our inspection 31 people were living there. At our last inspection on 14 August 2014 the service was found to require improvement in the Safe domain. Other key lines of enquiry were rated good.

There was no registered manager at the service. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The provider was actively recruiting for a new registered manager.

People felt safe living at Oaklands. People were protected from avoidable harm and abuse by staff who understood how to identify and report this. Staff were encouraged to raise concerns and were aware of who to speak with if they had any worries about anyone living at the home. Risks to individuals were managed and risk assessments in care plans were complete and up to date.

There were insufficient numbers of staff to meet people's care needs consistently and there were insufficient staff to support all people to follow interests when they wished. Medicines were managed safely and people received them in a timely manner.

Staff had the skills and knowledge to care for the people who lived in the home and training and induction for new staff was provided. Staff had an understanding of the Mental Capacity Act and people's consent was sought, on most occasions, before they were supported with their personal care needs.

People had enough to eat and drink and were supported to maintain a balanced diet. There was a sufficient and varied diet and nutritional needs were identified. Where necessary, extra support was provided to people ensure they had adequate nutrition. People were supported to maintain good health and access to health and social care professionals was available when they required this.

There were positive caring relationships in the home between the staff and the people they cared for. People were supported to express their views on some occasions, though this was not consistent. People's privacy and dignity was respected and maintained. There was a complaints process for people to use should they wish to do this.

There was no registered manager in post but there was a deputy manager who was well regarded by both the staff and people living in the home. Quality audits in the home were undertaken but the action points from those was audits were not always actioned.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was safe.

People were protected from harm by staff who were aware of how to identify abuse. Staff knew what to do in the event they identified abuse.

People were protected by safe recruitment processes which helped to ensure their safety. There were usually sufficient staff on duty to meet people's care needs.

Medicines were stored and administered safely and accurate records were maintained.

Is the service effective?

Good

The service was effective.

People were supported by staff who had the appropriate training and knowledge to work with people in an effective way.

Staff understood the principles of the Mental Capacity Act and Deprivation of Liberty Safeguards.

People were supported to access external health care services when this was required.

Is the service caring?

Good

The service was caring.

We saw kind and caring interactions between people and the staff who supported them.

People's privacy and dignity was maintained.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People's views and preferences were not always sought with regard to how they liked to live their lives.

People were not always supported to follow their interests.

A complaints procedure was in place and people and their relatives told us they felt able to raise any issues

Is the service well-led?

Good

The service was well led.

The home was managed by a deputy manager who was aware of the importance of keeping people safe in a caring environment.

There was no registered manager in place.

Oaklands (Nottingham)

Detailed findings

Background to this inspection

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

The inspection took place on 21 June 2016 and was unannounced. The inspection was undertaken by one inspector, one specialist advisor (nursing) 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 the inspection we reviewed relevant information, including notifications sent to us by the provider. Notifications are changes, events or incidents that providers must tell us about. We also contacted the local authority who commission services from the provider and Healthwatch which is an organisation that works with people who live in this type of home. We also spoke with a nurse from the local GP surgery. We asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what it does well and improvements they plan to make.

We spoke with five people who used the service. Not everyone who used the service could fully communicate with us and so we also completed a Short Observational Framework (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We spoke with four people who were supported by the service and four relatives of people who use the service, the deputy manager (who is also a nurse), three nursing assistants, two care assistants and the cook. We looked at three people's care plans and we reviewed other records relating to the care people received and how the home was managed. This included some of the provider's checks of the quality and safety of people's care, staff training and recruitment records.

Requires Improvement

Is the service safe?

Our findings

People told us they felt safe living at Oaklands. One person said they felt "Very safe" and their relative said "[person] is safe and secure here". Another person told us "I'm okay here" and another relative said "I feel very much so that [relative] is safe as I know how good the staff are", they also said "I've got peace of mind".

Staff members had a good understanding of the various types of abuse and knew how to report any concerns, both internally and externally. They were also aware of the whistleblowing policy and knew how to report and escalate any concerns. The Whistleblowing policy is to protect staff from being treated unfairly by their employer if they raise any genuine concerns about a person's care. The provider had policies and procedures in place for protecting people from abuse and staff were aware of these. One member of staff explained to us what action had been taken recently when there was a safeguarding concern. We saw incidents and accidents were recorded along with any follow-up actions.

Where risks relating to people's care had been identified risk assessments had been carried out monthly. For example, some of the doors within the home were secured with codes and these were changed on a regular basis as it had been identified one person would watch staff to learn what the codes were. This put them, and other people, at risk from areas of the home which could have been a danger to them. For example, giving access to where cleaning fluids were stored which they could have consumed.

People told us they were involved in the risk assessments for their care and they valued this. We saw up to date risk assessments for falls, pressure area care and weights. We also saw evidence of a bed rail assessment for one person and it was recorded in the care plan the person needed to be checked hourly. Charts showing the person had been checked had been consistently completed. The staff we spoke with were aware of how to support people to move and mobilise in a way which kept them safe. This showed the provider was aware of the need to keep people safe by looking at different situations and responding to them.

Another way people were kept safe was by staff looking at handover sheets when they came on shift. We saw these handover sheets being used on the day in careful way to ensure important information was passed from one staff shift to the next. One member of staff said they did this to make sure people's needs hadn't changed and they were still meeting them in a safe way. For example if someone required a change to their diet. By handing over information about the activities and change in needs of people living there the provider was helping to ensure people were kept safe.

We spoke with staff about what they would do if they identified any other concerns about risks for people, for example, if discovered someone had red skin. Staff were clear they would commence two hourly turning and would contact the Tissue Viability Nurse. They also said they would use the Telemedia system. Telemedia is a way of using a computer and a camera to send photographs to the GP surgery. In this way they could show wounds to health professionals and seek urgent advice which is a timely way of getting medical support for people.

Relatives told us they were generally happy their family member was receiving the appropriate checks to make sure they were safe. One family member who had a relative living in the home with skin that was at risk from breaking down said "[person] gets checked hourly and has a chart in the bedroom". They went on to say "[person] had a red mark recently and the carer noticed and was straight onto it". In this way staff were ensuring the changing needs of the people they supported were addressed in a timely manner.

However, we saw in the main lounge on the ground floor some people were left unattended for twenty five minutes. Four people were in the room during this time and no member of staff came to check they were safe. Some of the people in the room were able to move independently which meant they could have put themselves at risk by mobilising without support.

People told us there were not always enough staff on duty to meet their needs in a timely way. For example one person said "I don't recall many staff around, also I'd like to see more of them. They get shortages and then staff don't turn in". One relative said "They could do with some more staff; they've got so many patients here".

When we spoke with staff they told us they sometimes feel there are insufficient staff on duty, one member of staff said "We could do with extra staff". People living with dementia all lived on the first floor of the home and one member of staff expressed the view that people on the first floor were unable to walk out into the garden if the weather was good. This was because they would have to be escorted by a member of staff and there weren't always enough staff to respond to people in this way to help ensure they stayed safe.

The deputy manager told us they believed there were enough staff on duty and it was important the skill mix was the right one. They explained there was always a qualified nurse on duty who were well supported by the nursing assistants. However, one relative said "There should be someone in the lounge all the time; I have to go off and find someone if a person is asking for the toilet".

During our inspection we found there were insufficient staff on the ground floor to keep people safe. On the first floor where people living with dementia were supported there were sufficient staff to keep people safe and support them in a timely manner to minimise risk.

We looked at three staff recruitment files in the home. We found the staff received an induction to the service and that pre-employment checks had been carried out. There was information in nurse staff files which confirmed all nurses were registered with the Nursing and Midwifery Council. This meant they had the appropriate registrations to work as qualified nurses.

People told us they believed they were getting the medicines they needed when they needed them. One person said "They stay with me while I have my tablets". A family member said "I've no worries with it at all". We looked at 15 medicine administration record (MAR) charts and could see there was clear information about when people could receive pain relief medicine without consulting the GP. We could also see these had been given when people identified they were in pain. We saw staff made sure people had swallowed their medicine before the MAR chart was signed.

There were appropriate measures in place to ensure medicines were given safely. The clinic room and fridge temperatures were checked twice a day to ensure medicines were kept at the correct temperature. We saw records showed stocks of drugs were checked during every shift. All creams, lotions and eye drops and had opening dates on them to ensure out of date medicines were not given to people. This is because out of date medicines can be less effective in their treatment. During our inspection we saw a member of staff noticed one person had dry eyes and they administered eye drops. This showed staff were responding to

people as their needs arose. The pharmacist visited the home every two weeks to check medicines were in order.

Good

Is the service effective?

Our findings

We spoke with people and their relatives who all told us they felt the staff were capable in their work. One person said "I think they're very good". One relative told us ". I will say that, they're well trained here". Staff gave us examples of the training they undertook, including safeguarding, understanding medicines management, eating, drinking and safe swallowing and skin integrity. When we looked at staff training records we could see this was the case.

Nursing assistants were a level of skilled staff to help support the nurses in the home. Their 'in house' training consisted of a wide range of topics, including understanding diabetes, an understanding of medical issues, diagnosis of conditions and basic life support. The nursing assistants told us they felt the training was good and they felt competent to undertake the role following the training. Records for the nursing assistants showed input and support from the deputy manager throughout the training. This showed the provider was training their own staff up to a level where they could support people who lived in the home more effectively.

We looked at training records for all staff and could see this was up to date with training in emergency procedures, food safety, infection control and safeguarding. Staff told us they undertook an induction when they first started working in the home to ensure they had the correct skills to carry out their responsibilities. This involved shadowing more experienced members of staff until they understood what their tasks were and how to care for people using best practice. We saw during our inspection that people were cared for in a skilled and knowledgeable way.

However, staff supervisions between staff and their line managers were not up to date or consistent with the policy. Staff supervisions are designed to support staff and to enhance their learning and best practice when caring for people. When we spoke with staff they told us that, even though they had not had formal supervision, they could always ask for advice any time. When we discussed this with the deputy manager they told us their own supervision was not as frequent as the policy said it should be. This lack of staff support meant staff were undertaking their responsibilities without the full backing that should have been available to them.

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. Staff we spoke with understood the concept of capacity and were aware how to offer people choices about simple things if they were unable to make big decisions. Staff told us that there had recently been an application for a Deprivation of Liberty Safeguards (DoLS) for someone and they understood the need for this.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. 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 and could see from records they were.

We saw instances of staff asking for consent before supporting a person with care, for example asking if they wanted assistance to use a hoist to move them into a wheelchair. However, we saw no consent being asked before putting aprons on people at lunch time or before moving two people away from the table after lunch. Comments from people and family were mixed with one relative saying "They will ask [person], even though [person] can't talk or respond". However, another relative told us "They don't usually ask [person] before, they just get on with it". This shows consent to support is not always sought before it is undertaken.

People told us that, on the whole, they enjoyed the food. One person said "It's good; [person] is a good cook. I like the corned beef hash". They went on to say "There's usually two choices or you can ask for a salad. I could get a snack if I asked". Staff told us they watched people's facial expressions and body language to see if they were enjoying their food. If they were not people were offered an alternative. We saw drinks were available at meal times and also from a tea trolley twice a day. People were encouraged to take a drink and were offered a second. A squash dispenser was located in one lounge and a jug of water was seen in some bedrooms, though not in all.

Diet notification sheets were kept in people's rooms and these were updated on a daily basis. We checked the charts following the lunch time meal and could see they had been completed correctly. Staff explained how they encouraged and supported people to eat when they did not want to eat, or were struggling, for example, they may give them a spoon rather than a knife and fork as this was easier for them. One family member told us they had given their relative easy to hold cutlery so they could be more independent when eating. This person was supported by the staff to use the special cutlery which helped to ensure they were maintaining a healthy level of food intake. We could see from weight charts people were weighed weekly and action taken if they had lost weight to ensure they were not at risk of malnutrition.

However, there was no menu on the blackboard, which meant people were unaware what was for lunch unless they could remember the conversation earlier in the day when they had made their choice at breakfast. We saw a bag of sliced bread was opened by staff in the dining room and people were offered this by hand from the bag, this was put on the tablecloth beside them. Tongues or gloves were not used to give the bread which put people at risk of cross infection.

We saw one person who required assistance with their meal being supported by a member of staff. However, the member of staff constantly got up to tend to other tasks and there was no continuity for the person to enjoy their meal. This meant the person was supported to eat their food intermittently and inconsistently and they were being offered food which would have been cold. We also saw one person cut up their lunch and then did not eat it and put their cutlery down on the table. A member of staff cleared their plate after about ten minutes and there was no encouragement or monitoring to ensure the person had eaten any food.

When we spoke with the kitchen staff they explained how they prepared food if people require a diet of a different consistency to help them with swallowing and keep them safe. They were also aware of who required a diabetic diet. There was fresh fruit and vegetables available in the kitchen and where food had been prepared or opened they were dated. This was so staff could ensure people ate food which was fresh and safe to eat. The cook explained they were happy to cook alternatives for people if they request them as long as they could get the ingredients.

People told us staff were very good at arranging for them to see the GP when this was needed. One relative

said "The girls are quick off the mark with the GP". People told us they also had access to other health care professionals when this was required, for example opticians and chiropody. One person said "The optician's been and I got glasses", also "The foot man comes now and then as well". Staff told us it was easy to access health care for people, and getting "GP's and Speech and Language Therapists (SALT) was no problem". We saw in care plans referrals for a dietician due to weight loss and where someone had been referred to SALT. There were also contact details easy to hand for medical professionals who may be required to support people who lived in the home. This meant they were quickly and easily available.

The home operates a Telemeds system which is a way of people and staff talking to GP's during out of hours through telephones and information technology so that health care and support can be provided from a distance. Staff said it was very helpful in getting advice for people if they wanted to contact GP's outside normal surgery times. This meant health advice was easily and readily available for people twenty-four hours a day.

Good

Is the service caring?

Our findings

People told us the staff were generally friendly and kind. One person said "They're very nice". One family member said "They're lovely girls". Another relative said "They've taken a lot of worry off me, the staff are so good, it's marvellous". A third family member said "They're very supportive of me as I visit most days. They even made a buffet and cake for my seventieth, such a lovely surprise". This shows the home were supporting and encouraging family members to visit the home and share celebrations with their relatives and other people.

Staff told us when new people came to stay in the home they got to know them by giving them time and talking to them. They explained how they would sit down so they were talking to people at the same level and used different ways of speaking with people. This was based on people's capacity to understand the spoken language. They also told us they listened to people and got to know their preferences and learned their past history as this helped to build relationships with them.

Staff gave us other examples of how they built relationships with people, one member of staff said it was important to be "Honest, kind and caring" with people so they learned to trust. Another member of staff said "The right tone of voice" was important when talking to people and a third member of staff said they used the "Local dialect" to talk to people when this was appropriate. This meant staff were aware of how the way they presented themselves and spoke affected the people they were working with. Staff also told us they used appropriate touch but only offered hugs if they were requested by the person.

Throughout the day we saw good interaction between staff and the people who lived in the home. We saw kind and caring interactions and staff showing a lot of support and compassion to the people they were caring for. For example we saw one person come into the dining room late for lunch and alone, they were tearful and a member of staff gave them a cuddle, settled them into a dining chair and talked to them kindly. We saw this made the person feel much calmer and they then entered into the lunch time activity in the dining room.

Staff told us all people living in the home were invited to see their care plans and daily records, though often people refused. However, people did tell us that independence and decision making was encouraged where a person was able to communicate or assist in their personal care. For example, one relative said "They'll let [person] do as much as possible". One person said "I can choose my bedtimes. I sort what to wear the night before". Several staff told us they looked at care plans so they knew how individuals liked to receive their care and what interests and hobbies they enjoyed. By supporting people to make choices about daily activities the home were supporting people to make their own selections about how they lived their lives.

People told us they felt they were treated with dignity. Staff told us they helped to ensure people maintained their dignity by closing bedroom doors and curtains when they were assisting with personal care. Also, when people required help with their continence needs they were supported to their rooms in a quiet and dignified way. We saw this happening on the day we inspected. We also saw one person

requested staff to assist them with moving from a wheelchair to a chair, this was done immediately and in a dignified and safe way. Another example was we saw a person spill a drink during breakfast, the member of staff attended to the person immediately and was extremely kind and gentle towards them. Staff were aware of the need to treat people in a way they would like to be treated themselves, one member of staff said I "Treat people the way I'd like to be treated" they went on to tell us how important it was to refer to people by the name they preferred.

We saw instances of staff knocking on doors and waiting for people to give them permission to enter their rooms. One relative said "They always knock, they're very polite and treat [person] with courtesy". Another relative told us how they helped to maintain people's privacy and dignity by closing curtains and doors before they supported people with personal care, they said "I know they shut the door and curtains. I've seen it". This meant people were treated in a way which helped to promote their dignity.

Requires Improvement

Is the service responsive?

Our findings

On the day of our inspection we did not see anyone wait to have their personal care needs met. We saw that call bells were responded to in a timely manner. One person said "I use it when I'm in bed, they come quite fast". We saw one person who was reluctant to get up and a member of staff offered to take them a cup of tea in bed so they could have a few minutes to feel better about getting up. We observed the drink being taken immediately after this conversion. However, some people told us their needs were not always met in a timely manner and relatives we spoke with confirmed this. When we spoke with one person about how quickly staff supported them if they required assistance with personal care they said "It takes some time".

When we spoke with staff they were able to tell us about how they supported people with their personal care in a way that was important to individuals. For example they told us there was one person who did not want to wash or change their clothes. They explained they would leave them for a while and go back later to see if they had changed their minds; alternatively, another member of staff may offer them assistance. Staff also told us they got to know when people were more approachable, for example, what time of day they preferred help with their personal care. This helped to ensure people were supported in a way that was acceptable to them.

We saw care plans were up to date and reviewed monthly. We could see from care plans that, where it was appropriate, relatives were invited to take part in their review and planning. One person living in the home had been given regular chair exercises to do by the occupational therapist and this was documented in the care plan. During our inspection we saw a member of staff encouraging the person to go through their exercises.

There was evidence that some people were encouraged to make choices and decisions for themselves about following their own interests. For example, one person was being supported to learn skills which would help them to move to a more independent living environment. When we spoke with them about this they told us they were very happy this was happening and they were enjoying their learning. One person told us they could choose to stay up in the evening and watch television and chat to night staff. Another person told us they were accompanied to the local sports facility to watch their favourite game.

However, there were no activities available or on offer on the day of our inspection. The activities co-ordinator works six hours, four or five days a week. One person told us they would like someone in the home every day for activities as they really enjoyed them. One person said "I don't think we often have things on". Another person said "We should have more trips". A third person said "I'd like to go to church but I'm not sure where". This showed the home were responding to the needs of some people to be supported to follow interests but this wasn't consistent across the home.

Staff told us they played games with people every day for about 45 minutes in the afternoon as this was the only time they had to do this. One member of staff told us the routine in the home was too task orientated and there was "Not always time for pleasure" for the people who lived there. Relatives also told us the staff did not have time to spend with people doing things people were interested in. One member of staff said

there was one person who had enjoyed gardening previously but was now unable to do this as they couldn't access the outside easily; the member of staff went on to say "People do get bored". We saw one person asleep on the sofa and when we asked about any activities they might be interested in we were told they enjoyed sport on the television, however, no-one attempted to switch on the television and engage them in what was happening. This lack of consistency in meaningful activity did not show an awareness of people's mental well-being.

People told us they didn't make many complaints, one relative said "I've never felt the need to complain". However, one relative was concerned about the absence of a registered manager in the home. They told us "We spoke direct to head office to get more action as there's no manager, about staff numbers and how and where they get used. We've not seen anything different though".

Staff told us they knew what to do if anyone complained to them about the support they or their relatives were receiving. They would talk to their line manager or the deputy manager and they were confident they would be listened to. We saw there was a complaints policy in place and complaints were investigated and responded to in a timely manner.

Good

Is the service well-led?

Our findings

There was no registered manager in post. The provider had been actively trying to recruit to the post but without success. People and relatives we spoke with told us they were able to speak with the deputy manager if they needed to. One person told us the deputy manager was a familiar figure around the home and always willing to help.

When we spoke with staff they spoke highly of the deputy manager. They told us they were supportive and approachable and worked hard to ensure the smooth running of the home in the absence of a registered manager. One member of staff said "[deputy manager]is the mortar of this building" and "Without [deputy manager] we don't know what we would do". Staff told us the deputy manager "Gives positive feedback" and how welcome this was.

We talked to staff about the culture in the home and one member of staff told us they were "Very much a team", also that staff are willing to learn and improve the quality of life for people living in the home. Another member of staff said "Well-led, definitely, as a team we all stick together". They also said they trusted the nurses with the care and support they offered people.

All of the staff members we spoke with shared an understanding of the service values. They had a consistent vision of what the service was trying to achieve and they were aware of their roles and responsibilities. Staff were familiar with the people they were providing support to and would have no hesitation in reporting any concerns they had to their line managers. They were also confident that any issues raised would be listened to and acted upon. They said the deputy manager was approachable and supportive. Staff told us they believed good quality care was provided in the home and that the culture enabled staff and people to feel positive about the home. However, one member of staff told us the home could provide a better service to people by "More investment in occupational activity" for the people who live in the home.

The service is helped to provide high quality care by the nursing assistances who were introduced into the staffing in the home. The deputy manager told us their role was to "Step up" to help the nurses and they believed the opportunity to progress kept staff motivated. They also believed it helped them to retain their nursing staff.

Quality assurance systems were in place to monitor and review the quality of the service in the home. The deputy manager undertook a daily walk around the home to ensure the environment was safe and clean for people to live in. We could see these were noted in records. There were monthly quality inspections undertaken relating to the environment, care plans and other aspects of quality monitoring in the home. However, the action plans leading from these were not all 'signed off' which meant though improvements in the quality of the service were being identified there was no evidence the improvements were being made.

Staff ensured people's safety and welfare was monitored through reviews of their care and risk assessments. They had taken appropriate and timely action to protect people and had ensured they received the necessary, care support or treatment. We also saw appropriate records and documentation in place to

monitor and review any accidents or incidents. This helped to identify any emerging trends or patterns and ensured any necessary action was taken to minimise the risk of reoccurrence. The home had notified the Care Quality Commission (CQC) of any significant events, as they are legally required to do.

The service had established effective links with health and social care agencies and worked in partnership with professionals from those agencies to ensure people received the appropriate care and support they required. A resident's survey was undertaken every six months so people were able to share ideas for improvements in the home. Relatives and residents meetings had been undertaken in the previous year, however, there had been no residents meeting since November 2015. We discussed this with the deputy manager and they explained it was because there was no registered manager in post. One relative said "We used to have a monthly meeting when a regular manager was here but not now". Another person said "I've been regularly [to residents meetings] but not lately. It was a good session". This meant that people who lived in the home and their relatives, were no longer included in decision making in the home.