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

Overall summary

This inspection visit took place on 16 and 17 December 2014.

Oakridge House can accommodate up to 82 people who require nursing or personal care, some of whom may be living with dementia.

The service is overseen by the registered manager. 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 the last inspection on 25 June 2014, we asked the provider to take action to make improvements to ensure people's care and welfare, meeting nutritional needs, cleanliness and infection control, staffing, and assessing and monitoring the quality of service provision. These actions had been completed.

Summary of findings

People were complimentary about the service they received. However, our own observations and the records we looked at did not always match the positive descriptions people and relatives had given us.

Although people told us they felt safe, we found there were some aspects of the medicines administration that needed improvement. These concerned record keeping and the administration of medicines that people take as and when needed on an 'as required' basis.

The planning and delivery of care did not ensure the welfare and safety of people who use the service, as care plans and records did not always reflect people's current needs.

There were enough staff to meet people's needs and a system was in place to monitor and adjust staffing levels if people's needs changed. The service carried out appropriate recruitment checks to help ensure that staff were suitable to work with people at risk.

Staff were aware of their responsibilities to keep people safe and were confident to use relevant policies and procedures to raise any concerns. Staff received training and supervision to support them to deliver care effectively.

People received on-going support to meet their health needs and had access to relevant health care professionals. Where people lacked the mental capacity to make decisions, records showed that decisions were made in their best interests.

The atmosphere in the home was calm and staff interacted with people in a friendly, respectful and caring manner. Staff responded promptly to people's requests for support and knew the people they were supporting well.

Staff were well supported by the registered manager to undertake their roles and responsibilities. A regular programme of monitoring and quality assurance supported the staff and registered manager to assess the quality of the service and implement improvements. The registered manager actively promoted good relationships with staff, relatives and other professionals.

At this inspection we found one breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see the action we have asked the provider to take at the back of this report.

Summary of findings

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

Some aspects of this service were not safe. People received their medicines, however, the record keeping and the administration of 'as required' medication did not always follow good practice.

There were enough staff to meet people's needs and the service carried out appropriate recruitment checks to help ensure that staff were suitable to work with people at risk.

Staff were aware of their responsibilities to keep people safe and were confident to use relevant policies and procedures to raise any concerns.

Is the service effective?

Good

The service was effective.

Staff received relevant training to support them to deliver care effectively.

The staff and management of the service were knowledgeable about the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards and appropriate applications had been made where a person was deprived of their liberty.

People were supported effectively to make sure they had enough to eat and drink.

People had access to relevant health care professionals and received appropriate on-going support to meet their health needs.

Is the service caring?

Good

The service was caring.

The atmosphere in the home was calm and staff interacted with people in a friendly, respectful and caring manner. Staff knew people well, their likes and dislikes and responded promptly to their requests for support.

Is the service responsive?

Requires Improvement

The service was not always responsive. There were some inconsistencies with care records putting people at risk of not having their needs responded to appropriately.

People knew how to complain and information was available around the service to support this. The registered manager had a system in place to respond promptly to any complaints received.

Is the service well-led?

Good

The service was well-led. The registered manager actively promoted good relationships with people, staff, relatives and other professionals.

Summary of findings

Staff were well supported by the registered manager to undertake their roles and responsibilities. A regular programme of monitoring and quality assurance supported the staff and registered manager to assess the quality of the service and implement improvements.

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 functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 16 and 17 December 2014 and was unannounced.

The inspection was led by an inspector who was accompanied by a specialist advisor and an expert-by-experience. A specialist advisor is someone who has experience and knowledge of working with people who are living with dementia. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert-by-experience on this inspection had personal experience of caring for someone who lived with dementia.

Before we visited the home we checked the information that we held about the service and the service provider, including notifications we received from the service. A notification is information about important events which the provider is required to tell us about by law.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We reviewed a range of care records for eighteen people, including nursing and personal care assessments, medicine administration records, daily health monitoring records and visits by healthcare professionals. We also reviewed records about how the service was managed, including risk assessments and quality audits.

We spoke with nine people who live in the home and five relatives of people who use the service. We also spoke with the registered manager, two deputy managers, two assistant unit managers, two nurses, eight care staff, a member of the cleaning staff and two kitchen staff. We also spoke with the service manager at the end of the inspection. Following the inspection we received feedback from three external health and social care professionals who were regularly involved with the service.

Requires Improvement

Is the service safe?

Our findings

All of the people we spoke with said they felt safe living in the home. One person told us "I always get my medication the same time every day. The staff are very good and kind. They look after me well and keep me independent".

However, we found there were some aspects of the medicines administration that needed improvement. These concerned record keeping and the administration of 'as required' medication. The provider had used protocols and assessments to assess people's pain. However, these were not detailed regarding each individual's signs of pain and were not systematically applied to all the people who may have needed them. We found information in one care plan stating the person became distressed and withdrawn when in pain but there was no information about how to prevent the person being in pain before becoming distressed by it. For other people there were protocols for the use of pain relief and staff said they knew people well. The protocols did not provide clear details of how the person expressed that they were in pain and there was no system in place to monitor if a person's pain was worsening. A protocol or care plan was not in place for other 'as required' medication to tell staff when it was needed.

We recommend the provider review their practice with regards to as required medicines and pain assessments in line with best practice.

We found that checks were carried out in line with good practice on the nursing unit for people prescribed a medicine to regulate heart rate. The registered manager subsequently informed us that the community nursing team carried out these checks for the people in the residential unit.

The service had a policy and a set of procedures to support staff in the obtaining, recording, handling, using, safe keeping, dispensing, safe administration and disposal of medicines. The staff training programme included medicines management and a competency test. Care and support plans contained guidance about the levels of support individuals received in relation to medicines.

There were systems in place to reduce the risk and spread of infection. Named staff were appointed to take lead roles in monitoring Infection Prevention and Control (IPC) procedures and practice. In addition to this the management carried out regular audits.

A member of the domestic staff told us about the cleaning schedules, which included regular deep cleaning to reduce risk of infection. They showed us records of the daily cleaning requirements that were signed by the staff when completed. They were aware of the guidance and information that was available to follow in the event of an outbreak of infection in the home. They confirmed that staff had received relevant training and that staff working practices were monitored as part of the IPC audits.

People's rooms and the communal areas were clean. However, ten people on the ground floor nursing unit had net curtains across the doorways to their rooms at a height of approximately four feet. Almost all the net curtains had some discolouration and/or staining. A member of the domestic staff was unable to tell us what the cleaning programme was for the nets. A nurse told us "The relatives provide them for residents but we do not know whose responsibility it is for cleaning them." As a consequence these nets were not cleaned appropriately and may have posed a risk of infection transfer.

Staff wore personal protective equipment, such as gloves and aprons when cleaning, providing personal care and when serving food. Staff changed gloves and aprons between tasks. The home had arrangements for the disposal of clinical waste and the management of laundry to reduce the risk and spread of infection.

The service had written policies and procedures in relation to safeguarding people at risk. Staff received relevant training, knew what signs of abuse to look out for in their daily practice and who to contact if they suspected anyone was being abused. A nurse told us "We discuss this a lot in our meetings and whenever there is a safeguarding alert. I think we all know this really well. It is my job to ensure I know the safeguarding policy and follow it so that the residents are protected." A care worker told us "The purpose of safeguarding is to ensure people's safety so that if we see a mark or a bruise, we have to report it straight away, fill in a body map and write about it in the resident's records."

Requires Improvement

Is the service safe?

Behaviour support plans were in place for people who may become distressed or agitated, for example when being supported with personal care. We asked one care worker how they would respond to this and they told us "I back off and get someone with a different face, it can be as simple as that".

A senior member of staff told us how staff monitored the whereabouts of a person whilst not restricting their movements. Another person, who had limited mobility, chose to walk independently using the handrails in the corridors. We saw that appropriate support guidelines had been recorded.

The environment was free of any potential trip hazards and there were handrails on both sides of the corridors. The handrails were a different colour to the walls to make them more visible. People had keys to their rooms so were able to lock them when they were out. Staff would still be able to access the rooms in an emergency.

The rota was planned and organised in advance to help ensure there were sufficient numbers of suitable staff to keep people safe and meet their needs. Dependency assessments were carried out on an individual basis, for example when a person's needs changed, and were used to inform staffing levels. The staffing levels at the time of the inspection matched those recorded on the rota.

Appropriate staff recruitment processes were in place. There was a system for ensuring relevant checks had been completed for all staff. This included Disclosure and Barring Service (DBS) checks; confirmation that the staff were not on the list of people barred from working in care services. Checks were also undertaken to ensure that nursing staff were correctly registered with the Nursing and Midwifery Council (NMC). All nurses and midwives who practise in the UK must be on the NMC register.

Good

Is the service effective?

Our findings

People we spoke with all thought their health needs were being met. One person said "The staff are pretty good I feel well cared for and they keep me independent. They always ask my consent. I have had a flu jab and I am down to see the chiropodist". A visitor told us "This is a smashing place to live. It is nice and clean. My mum is well looked after and the food is very good".

Since the last inspection, significant improvements had been made in relation to the dining experience. Tablecloths were in use and flowers and menus were on the table. Coloured plates had been purchased, which would be of benefit to people with dementia, who may find it difficult to differentiate objects. One person had a plate guard to help them to eat independently.

Staff supported people to eat in an unhurried fashion and spoke about the food and how it was cooked. However, when staff asked people what they would like to eat for meals they used multiple answer questions. This language can be confusing to people with cognitive impairment.

People were able to make decisions about where they took their meals and what they wanted to eat. During the lunch time meal, at different times, two people indicated they wanted to remain in the lounge and not go through to the dining area. On both occasions, a member of staff asked them if they would prefer a sandwich. When the person said they would, the member of staff asked them what sort of sandwich they would like and then brought this to them on a tray in the lounge. Another person kept moving between communal areas and would not sit down to eat. Staff followed the strategy of leaving a plate of 'finger food' where the person would pass through. The person would take some of the food as and when they wished. Records showed the person's nutrition and weight was being monitored. Kitchen staff were aware of any special diets and a record was kept in the kitchen, so that staff preparing food had accurate and up to date information about people's requirements and preferences.

People's health needs were referred to health professionals appropriately. We received positive feedback from three health and social care professionals, who took part in ongoing quality reviews of the service. At these meetings any concerns about people's health care and support were discussed. One health and social care professional told us staff were very proactive and made necessary referrals as appropriate, for example communicating with a GP about a person's pain issues resulting in a medical scan being booked. They also said staff were very aware of mental capacity issues and of best interest decision making processes. They told us the standard of care they had seen was good and people's health was maintained. This was further confirmed by the other two external care professionals.

Staff confirmed that they received training that was relevant to their work and helped them to meet the needs of people using the service. There was a comprehensive induction, training and development programme and a system for monitoring staff attendance on courses. The induction for new care staff lasted four weeks and was based on the Skills for Care common induction standards, which, at the time of the inspection, were the standards people working in adult social care needed to meet before they can safely work unsupervised. In addition to essential training to carry out their roles safely, care staff attended dementia awareness training and were encouraged to undertake diplomas in health and social care. The registered manager told us the provider had commissioned a review of the dementia training provided to staff and a date was set for this to take place.

Staff knowledge and skills were supported through supervision meetings and individual performance plans, which provided an on-going appraisal of their work and development needs.

A Practice Development Nurse (PDN) worked between two of the provider's homes. The PDN supported the nursing staff to maintain and develop their clinical skills. One member of staff told us that supervision meetings could be difficult to arrange if the supervisor only worked nights. Another member of staff also said supervisions were infrequent due to the differences between their shift pattern and that of their supervisor. They said they felt they could approach senior staff, including the registered manager, for informal supervision if they felt they needed to. A third member of staff told us there had been "a blip" in supervisions but that these were now back on track.

The Care Quality Commission (CQC) monitors the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. These safeguards protect the rights of people using services by ensuring that if there are any restrictions to their freedom and liberty, these have been agreed by the

Good

Is the service effective?

local authority as being required to protect the person from harm. The manager understood when a DoLS application should be made and how to submit one. Following a Supreme Court judgement which clarified what deprivation of liberty is, the management had reviewed people in light of this and submitted more applications to the local authority.

We found the home to be meeting the requirements of the Deprivation of Liberty Safeguards. Records were kept of applications submitted and those that had been authorised. Named staff were appointed to take lead roles in checking that applications and supporting information were sent to the authorising body.

Where people lacked the mental capacity to make decisions the home was guided by the principles of the Mental Capacity Act 2005 to ensure any decisions were made in the person's best interests. Where decisions about everyday living where made for people by staff, mental capacity assessments were also recorded in their support plans. Staff received training in the fundamental principles of the Mental Capacity Act 2005. Staff demonstrated a clear understanding of the principles and their responsibilities. We saw staff asking people if they wanted to join in with activities within the home and seeking agreement when carrying out care tasks.

Good

Is the service caring?

Our findings

People told us that visitors and relatives were welcome at any time. We saw visitors in the dining room having coffee with their relative. One person told us “I am happy here”. One person said “The care staff can be busy. They always knock on the door they respect me by drawing my curtains’ (the person’s room was on the ground floor). They come and chat to me when they have time”. A relative told us the staff were sensitive, caring and kind. They said “The staff here are wonderful, it is truly a home from home. The staff keep me fully informed about X’s care and I trust them implicitly”.

The atmosphere in the home was calm and staff interacted with people in a friendly, respectful and caring manner. Staff responded promptly to people’s requests for support. One person appeared distressed and unsteady on their feet. The care staff engaged with the person and let them move around as they wished. The person was unable to communicate verbally and was rubbing their stomach. One of the care staff said to the person “You are not your normal self. Shall we see if the nurse can help? Have you got a stomach ache?”. A care worker took time to sit and talk with two people while she completed care records. The care worker made eye contact with both people and encouraged them to drink. While neither of the two people were able to hold a conversation, they were laughing and enjoying the company of the care worker. Another member of staff approached a person and asked if they were okay, noticed that the person looked cold and took them to find a cardigan.

Staff knew people’s likes and dislikes. A member of staff told us “We do 12 hour shifts so we really do get to know each resident and what they like. We spend a lot of time with them. We know some residents like to sit at a table on their own; they are happy doing that and we respect it is their choice”. We observed a staff member chatting with a person and encouraging them to drink more. Another member of staff told us “I get to know the residents by talking to them and reading their care plans, we also ask the family about their history that is how we learn about our residents”. We saw one person got out of bed later in the day. Staff were aware of the person’s preferences and told us they let the person decide when they want to receive their care.

Meetings were arranged, if appropriate, with people’s relatives to discuss end of life care arrangements. Staff had been involved in workshops about end of life care, following a suggestion made by an external healthcare professional.

Requires Improvement

Is the service responsive?

Our findings

People we spoke with were not aware of their care plans or if they were reviewed. One visitor told us "They review her care occasionally".

People's records contained a range of risk assessments and care plans, most of which were complete and up to date. These were reviewed on a monthly basis. However, we found some issues had not been identified in reviews. For one person, there was no guidance for staff about ensuring their skin was kept clean and dry and which barrier creams should be used, as is standard practice in cases of moisture skin damage. Another person's mobility care plan had not been updated to reflect the change in their condition after they were no longer able to mobilise using a walking frame and were being cared for in bed. This may put the person at risk of receiving unsuitable care.

We saw one person lying on their bed, which had some sections of bedrails raised and others lowered. This left a significant gap in the middle, which presented a potential entrapment hazard for the person. An electrical plug and cord was also directly accessible to the person, which could also have been a hazard. At the head of the person's bed were floor mattresses, which are used to protect people if they fall from bed. A member of staff told us "Care staff must have helped (the person) to bed and they should not have put the bed rails up, they could climb over the top. We also do not know why the crash mats are not in place". The person's care plan had not been updated to include the use of bedrails. We pointed this out to the registered manager and the care plan was subsequently updated.

We found when people had urinary tract infections their records did not contain a care plan that would help prevent a further infection. Where people have had more than one infection in a twelve month period, they should have their fluid intake monitored together with clear intake targets to guide staff. This was not routinely happening.

Each person whose records we saw had an individual nutritional assessment and support plan. The assessments were carried out on a routine basis, including monthly weight checks. However, we found weight loss was not always well managed. We found that four people had lost weight and the provider had referred them to their GP. We did not see clear care plans to increase the person's nutritional status, such as the provision of snacks and fruit and smoothies which meant there was insufficient information for staff to support people with their weight. We found one person had a nursing intervention care plan for loss of weight, however, records did not show that the instructions in this plan were consistently followed. There were no details about the progress of referrals to relevant professionals such as the GP.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 relating to person centred care.

An external health and social care professional told us staff contacted the tissue viability nurse for advice when necessary. They said they were continuing to work with staff at the home in order to improve recording in care plans and risk assessments and achieve a consistently high standard.

All three health and social care professionals told us the service was responsive to people's changing needs. For example, the management were working with the community social work team and the Older Person's Mental Health team to assess the suitability of the service to continue to meet one person's needs.

Health and social care professionals told us the activities provided social interaction and stimulation and some special events were provided and relatives were often invited. There was a pantomime taking place on the day of the inspection and a number of people's friends and relatives were in the home. A visitor told us "The care staff always ask if she would like to join in with the activities. She likes knitting and they have a knitting club".

All the people and their visitors knew how to make a complaint if they needed to. Some people told us they had made complaints in the past, which had been responded to and they were satisfied with the outcome. A system was in place to monitor and respond to any concerns or complaints about the service. The registered manager kept records of complaints, the actions taken in response and the outcomes. For example, one person had complained about not receiving assistance they had requested from a member of staff. The complaint had been taken through

Requires Improvement

Is the service responsive?

the appropriate channels and performance management procedures had been implemented. This demonstrated that the manager and provider listened to people's experiences and concerns and took action when necessary.

Good

Is the service well-led?

Our findings

People said they would recommend the home to others. A visitor told us "Someone always asks me on my way out if everything is OK and it is. We are very happy with this home".

The majority of staff we spoke with were positive about how the service was managed. One care worker told us "The home has changed for the better. I feel supported and we have good managers. As care staff we all get on and work as a team". Another care worker said "This home has a culture of fairness and openness". They said their comments and feedback were listened to and the registered manager was supportive..

Regular relative and resident meetings took place to discuss updates and feedback for the service. The provider had conducted a survey in May 2014 of peoples' views about the quality of the service. The manager told us how any issues raised by surveys or other feedback were addressed through an on-going quality improvement plan. This was a record of actions taken in relation to audits, incidents, and feedback from people using the service or others acting on their behalf. A copy of the report was sent to the service manager and provider. Records were kept of other audits that had taken place, including the completion of any identified actions. For example, an infection prevention and control audit had identified the need for more cleaning of shelves and cupboards and this had been followed up. The management also carried out 'walkabouts' in order to monitor the quality and safety of the service. The record of one of these checks showed that the proper use of personal protective clothing such as gloves and aprons was monitored.

We received feedback from a health and social care professional who took part in review meetings involving the registered manager and lead staff, ambulance service, the linked social worker for the home and sometimes a community nurse representative. They told us they found staff at the service to be transparent, proactive and always striving to improve their services. An example of this related to poor clinical information previously provided to out of hours services, relating to patient clinical history. This had improved and at one of the meetings an out of hours GP had commented on the high standard of patient handover they had received.

This was also confirmed by two other social care professionals who provided us with feedback. They told us the service worked in partnership with them and contacted them appropriately if there were any concerns about people who used the service. They said ambulance call outs had reduced as a result of the management being open to suggestions and adapting their protocols with regard to call outs. The service had also acted upon a suggestion to improve communication channels with relatives and visitors. They told us the manager and staff were striving to deliver a high standard of care and when any shortfalls were identified they were responsive to suggestions and endeavoured to address and improve.

Procedures were in place for reporting accidents and incidents, including a system for monitoring risks. For example, in the event of a pattern of falls being identified, the internal local governance team would contact the home to check what action was being taken.

The service had a whistle blowing policy and procedure in place and staff were aware of it. Staff told us they would feel confident in raising any concerns about poor practice and that the management would respond appropriately. A nurse said "I would not hesitate to report an issue if someone was at risk and I know the manager would refer it on as she has done in the past. We have no secrets here."

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care **The planning and delivery of care did not ensure the welfare and safety of people who use the service as care plans and records did not always reflect people's current needs. Regulation 9 (3) (b).**