Bethesda Healthcare Ltd

Oaklands Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service:
Oaklands Care Home was registered under a new provider in November 2018. The service is registered to provide care and support for up to 31 people.

People's experience of using this service:

The provider did not have robust systems in place to ensure people were protect from avoidable harm.

Documentation relating to the care and support people required was not always accurate or person centred.

Investigations into incidents and accidents were not always analysed to learn lessons and prevent future occurrences.

Complaints were not consistent dealt with in an appropriate manor.

Governance systems were not always effective in driving improvement.

Requirements of the Mental Capacity Act 2005 were not consistently applied.

People were not always treated with dignity and respect.

People were not always provided with appropriate meals.

Activities were not always person centred and staff were not able to spend reasonable lengths of time with people to meet their social and emotional needs.

The provider was in the process of developing the environment to ensure it supported people who were living with dementia to remain safe and as independent as possible.

Staff understood how to raise a safeguarding concern and felt confident the provider would take action should any form of abuse be observed.

Staff were recruited safely, and people told us there were sufficient numbers of staff employed.

Relatives were complimentary about the quality of care provided.

Rating at last inspection:
The service had not previously been inspected

Why we inspected:

This was the first scheduled inspection following the homes registration.

Follow up:

We will continue to monitor intelligence we receive about the service until we return to visit as per our re-inspection programme. If any concerning information is received, we may inspect sooner.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

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 not always safe

Details are in our Safe findings below.

Is the service effective?

Requires Improvement

The service was not always effective

Details are in our Effective findings below.

Is the service caring?

Requires Improvement

The service was not always caring

Details are in our Caring findings below.

Is the service responsive?

Requires Improvement

The service was not always responsive

Details are in our Responsive findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led

Details are in our Well-Led findings below.

Oaklands Care Home

Detailed findings

Background to this inspection

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

Inspection team:
The inspection team consisted of two inspectors.

Service and service type:
The service is a 'care home'. People in care homes receive accommodation and nursing or personal care. The Care Quality Commission (CQC) regulates both the premises and the care provided, and both were looked at during this inspection.

The service did not have a manager registered with the Care Quality Commission. This means that only the provider was legally responsible for how the service is run and for the quality and safety of the care provided.

A manager had been recruited to this post and the provider hoped they would start early June 2019.

Notice of inspection:
The inspection was unannounced.

What we did:
We did not request a Provider Information Return (PIR).

During the inspection we spoke with three people, two relatives and two visitors. Many people using the service were unable to speak with us because they were living with dementia and could not tell us about their experiences. We spoke with four staff, including care, training and kitchen staff. We also spoke with the general manager and a representative for the provider.
Throughout the inspection we spent time in the communal areas of the home observing how staff

interacted with people and supported them.

We reviewed four people's care records, medicines records for 10 people, four staff's recruitment records, supervision and training records. We also looked at documents relating to the quality, safety and management of the service. After the inspection the provider sent us various policies and procedures, audits and records relating the running and management of the service. These were reviewed and used to support out judgements.

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm

RI: Some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed. Regulations may or may not have been met.

Assessing risk, safety monitoring and management:
• People were not always protected against risks associated with their care and support because risk had not been effectively assessed and plans implemented to reduce these.
• For example, the deputy manager told us about one person who had been found in a situation that was dangerous the week before our inspection. However, despite this, no formal risk assessment had been implemented and we found a number of items in their room that could increase the risk of a similar incident occurring. We were required to advise the registered provider to take action which they done so immediately.
• For a second and third person, we found they had been assessed as needing a texture modified diet by external professionals, due to risks of choking. However, no risk assessments had been implemented and for one person their nutrition care plan was blank. We observed that these two people were given meals outside of the professional guidance.
• We raised this concern and the deputy manager and provider took action immediately to ensure that all staff were aware of the recommended diet textures.
• Other areas of risk were managed but lacked records to show they had been assessed and mitigation plans developed. For example, one person was living with a number of health conditions that posed risks although these had not been assessed and no plans had been developed. The lack of records posed a risk that the person may receive inappropriate support by new staff who lacked knowledge of the person.

The failure to ensure risks for people were appropriately assessed, plans developed to mitigate the risks and professional guidance was followed, was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Learning lessons when things go wrong:
• It was not always evident that learning took place following incidents that occurred. For example, insufficient action had been taken following a dangerous incident for one person.
• For a second person who had suffered a number of falls over a relatively short period of time, no analysis of these had taken place to determine any patterns and preventive action that could be taken.

A failure to effectively evaluate the safety and wellbeing of service users and use this information to improve practice was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection:
• We could not be assured the provider had effective infection control procedures in place to ensure the

environment was consistently clean and free from the risk of cross contamination.
• During various times of the day, and at a number of different areas within the home, the environment had an unpleasant odour. A member of staff said, "The infection control could be better" and "Sometimes there is a strong smell of urine in the home".
• The home had a self-service breakfast station which provided six different cereal options for people to choose from. The table and the cutlery holder contained large amounts of food crumbs which was built up over a period of time.

Staffing and recruitment:
• At the time of our inspection there were five care staff working in the morning, four care staff working in the afternoon and three care staff working at night.
• People and relatives told us they felt sufficient staffing levels were in place. However, on the first day of our inspection there were occasions where staff were unable to spend time with people to provide explanations about their care or to have meaningful conversations with them. A member of staff told us they were not able always able to spend the time they wanted with people. They said, "We are so busy we don't get to sit and speak to people".

Systems and processes to safeguard people from the risk of abuse:
• During our visit we had concerns about the risks associated with the care two people received. We fed this back to the provider and the deputy manager who took immediate action and referred the issues to the local authority safeguarding team.
• People told us they had never observed any form of abuse and said they felt safe living in the home.
• Staff received training in safeguarding adults from the possibility of abuse. They knew the signs of possible abuse and were aware of their responsibilities to report it if it was observed.

Using medicines safely:
• The administration of medicines was safe, and people told us they were given their medicines when they needed them. However, some records required improvement.
• For medicines that were prescribed on an as and when required basis (PRN), guidance for staff on when to administer or escalate the use of these to a GP were not consistently in place.
• For medicines which posed increased risk of bleeding, risk assessments and plans to reduce, monitor and manage this had not been implemented.
• Storage of medicines was safe. Locked trolleys and a medicines fridge were stored in a locked room and the temperature of medicines storage was monitored daily to ensure it was within safe limits.
• Where needed the opening dates of medicines was recorded and monitored to ensure they were not used outside of their expiry times.
• Records were maintained to show when medicines had been received, administered and returned to the pharmacy.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence

RI:□The effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent. Regulations may or may not have been met.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
• We found no evidence in people's care records of pre-admission assessments taking place before people moved into the home to ensure they could meet people's needs, although we were told this happened by the provider and the deputy manager.
• Although some nationally recognised tools such as such as Waterlow (a tool to assess the risk of skin breakdown) and Malnutrition Universal Screening Tool (MUST- a tool used to determine the risk of malnutrition) were in place these were inconsistently used to determine risk levels to people and develop clear plans of care. For example, one person who we observed was at high risk of skin breakdown had a blank Waterlow assessment and no skin integrity care plan.
• For a second person, whilst a falls assessment tool was in place, this was not accurately completed, and the risk of falls was then not reflected in the person's care plan.

The failure to ensure risks for people were appropriately assessed, plans developed to mitigate the risks and professional guidance was followed, was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff support: induction, training, skills and experience
• Staff had completed a comprehensive induction which included the completion of the Care Certificate. The Care Certificate is an identified set of standards that health and social care workers adhere to in their daily working life. It aims to ensure that workers have the same introductory skills, knowledge and behaviours to provide compassionate, safe and high-quality care and support.
• All staff were supported through supervisions and appraisals.
• Staff received training and underwent regular competency assessments to ensure they had the skills and knowledge to support people effectively.

Supporting people to eat and drink enough to maintain a balanced diet
• Feedback from people indicated they were happy with food choices.
• Comments from people included, "This is lovely" and "Can I have some more please?"
• Relatives told us they felt staff provided people with sufficient opportunity to eat or drink at different times of the day.

Supporting people to live healthier lives, access healthcare services and support
• Daily records demonstrated staff sought advice from healthcare professionals when people became unwell.

• Relatives told us they were confident people's healthcare needs were met.

Ensuring consent to care and treatment in line with law and guidance
The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, whether any restrictions on people's liberty had been authorised and whether any conditions on such authorisations were being met.

• People told us they were listened to and that staff respected their decisions.
• Although staff spoken with demonstrated a good understanding of the principles of the MCA, this understanding was not reflected in care records. For example, one person had multiple capacity assessments which recorded they were able to consent to numerous elements of their care. However, a consent form in their file was incomplete.
• For a second person whom we were told was extremely confused, a consent form in their file had been completed to say they had provided consent to a number of area's but this had not been signed by anyone. We were told this person had been referred to older person mental health team due to their confusion and behaviours. However, no assessments of their ability to consent to the various aspects of their care, had been undertaken. An incident that had put this person at risk had occurred and as a result an item had been removed from the person's room. However, there was no record of capacity assessments and best interests decision making to demonstrate this was the least restrictive approach to take.
• DoLS applications had been submitted to the local authority but had not yet been assessed. The deputy manager was making contact with the local authority to try and progress these.

Adapting service, design, decoration to meet people's needs:
• A number of people living in the home were living with dementia, but the environment was not always dementia friendly. Some signage was in place, to access toilets for example but this was minimal. Memory boxes were outside people's room, but there was no signage to indicate these were bedrooms or photos that would help people identify the rooms were theirs. Directional signage was lacking.
• The provider had recognised the need to adapt the environment and had plans in place to undertake work such as, improve lighting in the dining room and replace carpets that could distract people with living with dementia. They had used research guidance to help develop these plans.
• By the second day of the inspection, the provider had sourced a dementia specific environmental audit that they told us they would be using to assess other areas of the environment. In addition, some directional signage was implemented such to support people living with dementia to navigate to the toilet.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect

RI:□People did not always feel well-supported, cared for or treated with dignity and respect. Regulations may or may not have been met.

Ensuring people are well treated and supported; respecting equality and diversity:
• People and relatives spoke positively about staff. One person told us staff were "Brilliant" and another person said, "They're very kind".
• Staff knew people well and we observed some very positive interactions. However, we also observed on occasions that some staff did not always communication well and provide good, clear explanations to people.
• For example, on one occasion we observed two members of staff supporting a person to transfer from a wheelchair to armchair, using a hoist. However, the battery was not working, and staff needed to find alternative batteries twice. The person was lifted up and placed back down in the hoist three times whilst staff found a battery that worked. However, at no point did staff explain to the person what was happening.

Supporting people to express their views and be involved in making decisions about their care:
• Staff supported people to make decisions about their care, for example, when they wanted to get up, what they wanted to wear, how they wanted to spend their time. Relatives told us they were kept updated and involved but we were unable to find evidence of people and their relatives' involvement in the development of their care plans.
• Staff understood peoples' communication needs although care plans regarding this need were minimal. People living with dementia did not always have a clear communication plan in place in order to assists staff to understand their communication methods and behaviours.

Respecting and promoting people's privacy, dignity and independence:
• On occasion we heard staff using language such as "doubles" and "singles" when referring to people. This was inappropriate, undignified and demonstrated a need to ensure staff were mindful of using respectful language.
• Observation demonstrated people's independence was supported as much as possible. People were encouraged to mobilise independently where they were able, and staff were observant and provided guidance where needed.
• People's rights to privacy and confidentiality were maintained. Care records were stored safely and securely. Conversations took place discreetly where needed. Staff were observed knocking and waiting before entering people's rooms.

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs

RI:□People's needs were not always met. Regulations may or may not have been met.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control:
• The deputy manager and provider told us that a decision had been made to change from an electronic care planning system to a paper-based care plan system. The deputy manager had set up files for all people in the service that staff could access on a daily basis. However, we found a number of these were incomplete and there were no plans of care to guide staff about people needs, wishes and preferences.
• The provider told us that the previous electronic records had been printed for staff while the changeover occurred, however they were unable to find these until late during the first day of our visit. On the second day these had been placed in people's files however we found that they were not always up to date or accurate and provided very minimal person-centred information.
• As a result, we were not confident that people's needs, and preferences were always considered, and plans implemented to provide support that met these.
• The deputy manager was aware of the need to improve the records but needed the time to do this.
• People told us staff knew them well and how to support them. Most staff had been working with people for a significant period of time and as a result had built relationships and developed a good understanding of people's likes, dislikes, preferences and needs. However, the lack of accurate and up to date records meant people may receive support that was not person centred and based on their needs and preferences.
• At the time of the inspection the provider was in the process of recruiting an activities coordinator. External activity providers were used to provider group activities.
• Two visitors told us that they felt staff didn't have time to sit and chat with people, or just spend one to one time with them. One member of staff also told us they felt staff didn't have time to provide a good level of social support to people.
• We observed staff interacting with people throughout our inspection, but this was limited to times when people needed direct support. We observed very little in the way of personalised and meaningful activities for people.

The failure to ensure people received person centred care was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• On the second day of the inspection we observed an entertainer singing and speaking with a number of people in the lounge. Some enjoyed the activity whilst others were not interested and chose not to join in.

End of life care and support:
• No-one living at the home was in receipt of end of life care. Staff had received training in end of life care and were able to tell us how they would ensure people needs, preferences and wishes were met. Although end of life care plan formats were in place, written plans to guide staff had not been developed which reflected this. The deputy manager was aware of this and had plans to develop these.

Improving care quality in response to complaints or concerns:
• Whilst the provider had a complaints procedure in place, we found one complaint had been made since the provider purchased the home, but we could not find any evidence that the issues had been acknowledged, investigated and acted upon. We fed this back to the provider who was unable to provide an explanation.
• No one in the service told us they had any complaints and were confident to raise concerns. They told us they felt they would be listened to and that staff and management would take action to address their concerns.
• One relative told us they had raised informal minor concerns in the past and were satisfied with the way these were managed.

The failure to ensure complaints were appropriately investigated and responded to, was a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires Improvement

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture

RI:Service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care. Some regulations may or may not have been met.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements.

- Leadership and management did not ensure person-centred, high quality care was consistently delivered. The provider had failed to ensure there was sufficient and effective oversight and governance at the service. Systems had not always been effective in identifying shortfalls and unsafe practices. As a result, safe standards of care were not consistently delivered.
- Governance systems failed to drive improvement in areas of dignity, equality and respect. The assessment of risk and the use of the MCA had not been monitored effectively. The provider failed to consistently create a person-centred culture within the home and investigations into safeguarding concerns and complaints were not always reports or investigated appropriately.

The failure to ensure governance systems were effective at driving improvement was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Staff said they were listened to by the deputy manager. They felt confident about raising any issues or concerns with the deputy manager at staff meetings or during supervision.
- Staff understood the whistle blowing policy and how to escalate concerns if the needed to, via their management team, the local authority, or CQC. Prior to our visit there had been no whistle blowing notifications raised at the home.

Planning and promoting person-centred, high-quality care and support with openness; and how the provider understands and acts on their duty of candour responsibility.

- Duty of Candour is a requirement of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 that requires registered persons to act in an open and transparent way with people in relation to the care and treatment they received.
- The deputy manager and the provider understood the requirement and were open and honest about the care and support people received.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- Photographs located throughout the home showed the provider had worked in partnership effectively with the public, including various education centres and relatives.

● The provider had policies and procedures in place to ensure they met their responsibilities under the Equality Act.
● All organisations that provide NHS or adult social care must follow the Accessible Information Standard (AIS). The aim of the AIS is to make sure people who have a disability, impairment or sensory loss receive information they can access and understand, and any communication support they need. The provider had an AIS policy in place and we found the principles of the standard were followed in some areas of the home. The deputy manager told us they would review AIS guidance and ensure any additional measures required were put in place. We will check that this has been progressed at the next inspection.

Continuous learning and improving care
● The provider sent us a number of quality assurance audits that detailed areas for improvement. The records provided a series of actions for staff to implement including the reviewing of people's care plans.
● The provider was honest about the areas of the home they wanted to develop and were passionate to share their intentions with us. This included the development of the home to ensure the environment was suitable for people living with dementia.

Working in partnership with others
● Records demonstrated staff made contact with external healthcare professionals when people became unwell, when they required dental care or when a district nurse was needed.
● Relatives told us they frequently observed professionals visiting the home.
● On the second day of our inspection we observed an ambulance present to assist one person. We were also made aware that a GP was visiting the home to see one person about a health issue.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations 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 will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider failed to ensure people were consistently provided with person centred care.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider failed to ensure appropriate plans were in place to assess and mitigate risk.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints The provider failed to ensure all complaints received had been appropriately investigated.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to ensure governance systems were consistently effective at driving improvement.