Cotdean Nursing Homes Limited

Oaklands Care Home

Inspection report

Wartell Bank ,Kingswinford, DY6 7QJ
Tel: 01384 291070
Website:

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Ratings

Overall rating for this service	Requires Improvement
Is the service safe?	Inadequate
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Requires Improvement

Overall summary

The provider is registered to accommodate and deliver nursing and personal care to a maximum of 40 older people. People may have a range of needs which include physical and mental health needs and old age. At the time of our inspection 31 people were living there.

We carried out an unannounced comprehensive inspection of this service on 30 October 2014. A breach of legal requirements was found. The issues relating to the breach placed people at risk as the provider had failed to handle and administer prescribed medicines in such a way as to maintain and promote peoples good health. After this inspection, the provider wrote to us to say what they would do to meet legal requirements in relation to Regulation 13 and the management of medicines. We undertook a focused inspection on 18 May 2015, to check that these actions had been taken.

The service had a registered manager at the time of our inspections. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

You can read a summary of our findings from both inspections below.

Summary of findings

Comprehensive Inspection of 30 October 2014

We carried out this unannounced inspection on 30 October 2014. At our last inspection on 17 June 2014 we found the service had not maintained accurate records in relation to the care and treatment provided to each person using the service. Following the last inspection we were provided with an action plan outlining the action the provider had taken to make the improvements. We saw that these improvements had been made.

People had personalised care plans and risk assessments in place that detailed their health and support needs, including their preferences, likes and dislikes. We saw that these were developed and reviewed with people and their relative's involvement.

There were systems in place to protect people from abuse and harm. Staff had a clear knowledge of how to protect people and understood their responsibilities for reporting any incidents, accidents or issues of concern.

We looked at staff rotas and observed that staffing levels were sufficient to support people when they needed it. People and relatives told us that they felt staffing levels were adequate.

People's nutritional needs were monitored regularly and reassessed when changes in people's needs arose. We observed that staff supported people in line with their care plan and risk assessments to maintain adequate nutrition and hydration.

Staff were responsive when people needed assistance and interacted with people in a positive manner, using encouraging language whilst maintaining their privacy and dignity.

The staff worked closely with a range of health and social care professionals to ensure people's health needs were met, for example physiotherapists and chiropodists.

The staff supported people to access support for their religious needs. Information from staff and the manager indicated that certain other elements of people's diverse needs were not routinely considered as part of a comprehensive assessment, for example sexual orientation.

Systems for gathering feedback about the service from a variety of stakeholders and monitoring quality through audits were well established. This meant the provider was proactive in seeking feedback to maintain and improve the quality of service delivery.

It was evident that the manager promoted a culture in the service of putting people's needs at the centre of decision making. Staff told us they could raise any concerns about the service openly with the manager.

Responsibility and accountability lines within the service particularly in regard to support for the registered manager were limited. The provider had failed to notify us of serious incidents that had taken place within the service.

We found that the medicines management arrangements were not robust. We observed that people did not always receive their medication in a timely manner and records in relation to the administration of medicines had omissions that were not accounted for. You can see what action we told the provider to take at the back of the full version of the report.

Focused Inspection of 18 May 2015

We undertook this focused unannounced inspection on 18 May 2015 to check that the provider had followed the action plan they sent to us and to confirm they now met legal requirements. This inspection focused on the management of medicines from 1 May 2015. We found that the provider had not taken the appropriate action to meet the legal requirements to meet the regulation.

We found that medicines were not always being administered in a safe manner and/or in line with the prescribing practitioner's instructions. Systems in place for the storage of medicines were effective.

This report only covers our findings in relation to our follow up of the breach and warning notice issued in relation to medicines management. You can read the report from our last comprehensive inspection by selecting the all reports link for Oaklands Care Home on our website at www.cqc.org.uk.

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?

30 October 2015

Inadequate

The service was not safe.

People who used the service were being put at risk as medicines were not administered in a timely manner and were not always handled or managed safely.

Risks for people in regard to their health and support needs were assessed and reviewed regularly. Staff acted in a way that ensured people were kept safe and had their rights protected when delivering care.

Staff were knowledgeable about how to protect people from abuse and harm.

18 May 2015

The service was not safe.

We found that the appropriate action had not been taken to ensure that effective medicines management was in place. The provider had failed to protect people from the risks related to medicines.

We have revised the rating for safe from requires improvement to inadequate. This is because the provider had failed to make and/or sustain the required improvements to meet the requirements of the law in relation to safe care and treatment.

Is the service effective?

30 October 2015

Good

The service was effective.

Staff received regular training and had the appropriate level of knowledge and skills to meet people's needs.

People's ability to make important decisions was considered in line with the requirements of the Mental Capacity Act 2005.

People were supported to access specialist healthcare professional input from outside the service to meet any changing needs.

Is the service caring?

30 October 2015

Good

The service was caring.

People and their relatives were complimentary about the staff and the care they received.

Summary of findings

Information about the service or their care was available for people using the service and their relatives.

We observed that people's privacy and dignity was respected by the staff supporting them.

Is the service responsive?
30 October 2015

Good

The service was not always responsive.

The provider had failed to respond to complaints received in a timely and effective manner.

People were actively involved in planning their own care. We saw that care was delivered in line with the person's expressed preferences and needs.

Activities offered within the service were planned in consultation with people using the service.

Visiting times were open and flexible enabling people to maintain links with family and friends.

Is the service well-led?
30 October 2015

Requires Improvement

The service was not always well-led.

The provider had failed to inform the Commission and other external agencies of incidents that had occurred within the service.

People and their relatives spoke positively about the approachability of the manager.

Elements of the provider's quality assurance systems lacked a robust system for addressing identified gaps or omissions.

Oaklands Care Home

Detailed findings

Background to this inspection

This inspection report includes the findings of two inspections of Oaklands Care Home. We carried out both inspections under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. These inspections were 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 first was a comprehensive inspection of all aspects of the service that took place on 30 October 2014.

That inspection identified one breach of the Regulations. The second inspection was undertaken on 18 May 2015 and focussed on checking that action had been taken in order to meet the requirements of the law. You can find full information about our findings in the detailed key question sections of this report.

Comprehensive Inspection of 30 October 2015

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

The inspection of Oaklands Care Home took place on 30 October 2014 and was unannounced.

The inspection team consisted of two inspectors, a pharmacist inspector and an Expert by Experience of mental health services. An Expert of Experience is someone who has personal experience of using or caring for uses this type of care service.

Before the inspection we reviewed the information we held about the service including notifications of incidents that the provider had sent us. Notifications are reports that the provider is required to send to us to inform us about incidents that have happened at the service, such as accidents or a serious injury. The inspection was undertaken at short notice in response to concerns we had received about medicines management in the service from the local Clinical Commissioning Group (CCG). The CCG is responsible for buying local health services and checking that services are delivering the best possible care to meet the needs of people. Following our inspection we contacted three healthcare professionals who had regular contact with the service and the GP to obtain their views about the care provided by the service.

During our inspection we spoke with seven people who use the service, four relatives, one member of kitchen staff, two nurses, five care staff, the registered manager and the director of the service. We observed care and support provided in communal areas and spoke to people in their bedrooms. We used a Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people using the service and staff interactions with them.

We reviewed a range of records about people's care and how the home was managed. These included pathway tracking four people by reviewing their care records, looking at the staff training matrix, three staff files, 14 people's medication records and the quality assurance audits that the registered manager completed. We looked at some policies and procedures where they related to safety aspects of the home and also looked at whistle blowing and safeguarding policies.

Focused Inspection of 18 May 2015

We undertook a focused inspection of Oaklands Care Home on 18 May 2015. This inspection was done to check

Detailed findings

that improvements to meet legal requirements planned by the provider after our inspection on 30 October 2015 had been made. We inspected the service against one of the five questions we ask about services: is the service safe. This is because the service was not meeting some legal requirements.

The inspection was undertaken by a pharmacy inspector.

We spoke with the registered and deputy manager. We looked at what arrangements the service had in place for the obtaining, recording, storage, safe administration and disposal of medicines.

Inadequate

Is the service safe?

Our findings

Findings from our comprehensive Inspection of 30 October 2014

Our Pharmacist Inspector reviewed how medicines were managed within the service. We found that medicines were stored safely and records were kept for medicines received and disposed of. However, we found that people's medicines were not always handled or administered safely.

People were not always given their medicines at the time specified by the prescriber. On the day of our inspection we arrived at 9.30 am and the morning medicine round was underway. We noted that two staff were administering medicines from two medicine trolleys. The medicine round for both medicine trolleys was lengthy and was not completed until 11.45pm. This meant that there was a risk that medicines were administered later in the day, particularly those scheduled for administration at lunchtime, may be administered too close together. We noted that one person was due to have their second dose of a medicine at midday; however they did not receive this dose on time. It was important that this medicine was given at the correct prescribed time to treat their diagnosed healthcare condition. There would also be an increased risk of the person suffering side effects from the medicine later in the day. Medicines are prescribed to be given at specific intervals in order that the effects are safe and that people gain the maximum benefit from them, for example continuity of pain relief.

Records we looked at did not always determine if people had been given their medicines as prescribed. There were arrangements in place to check stock levels; however we found gaps in some people's medicine administration records which had not been identified by the service. We saw two records that lacked a staff signature to record the administration of the person's medicines or a reason documented to explain why the medicines had not been given. Staff told us that these omissions had been made by an agency nurse so they were unable to explain why signatures were missing. It is important that medicine records are completed and checked as this is the only record to show that people have been given their medicine at the prescribed times.

Supporting information for staff to safely administer medicines was not always available. In particular we looked at two people who were prescribed a medicine to be given 'when necessary' or 'as required' for agitation. We found that there was no supporting information available to enable staff to make a decision about when to give the medicine. Staff were able to tell us when they would give the medication however the reason given was not documented. We further noted that one person was being given their 'as required' medicines every day which had not been reviewed with the prescribing doctor. A review would help to assess if a regular dose was needed or to investigate why it was needed to be given so often.

This is a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Medicine audits were completed by the manager every month. We saw that during the last check of medicines management two areas were identified as needing to be improved. We were shown what action had been taken to learn from these incidents in order to change practice to help improve people's safety. For example, we were shown new arrangements to ensure that people who were prescribed pain killers had their level of pain assessed and documented. We observed people receiving medication and being involved in discussions around their individual needs, for example in regard to their need for "as required" pain relieving medicines.

Relatives told us they were happy with the support available and that the environment was safe for their family member to reside in. One person told us, "I feel safe here". Another said, "Staff come to me when I need them ". One relative told us "I would be happy for any of my friends and family to stay here". During our visit we spent time in the communal areas and saw that people were at ease with asking staff for assistance and a relaxed atmosphere was observed.

Staff were able to tell us about the types of potential abuse, discrimination and avoidable harm that people may be exposed to and how they would respond to protect people. Staff had undertaken training in how to protect and keep people safe in a variety of ways, including safe moving and handling and fire safety. Staff told us training they had received had equipped them with the necessary knowledge and information in order to protect and keep people safe. Staff were clear about their responsibilities for reporting any concerns regarding abuse. We had received some notifications from the manager in regard to incidents

that had taken place within the service. We saw that the manager had also notified the local authority of such incidents where necessary. One staff member told us, "The manager always makes time to listen if I have concerns".

Records we looked at showed that assessments had been completed in respect of any risks to people's health and support needs. These referred to the individual's abilities and areas that they needed assistance with in order to avoid harm and reduce any related risks. For example, through our observations we were able to see how staff used equipment in such a way as to protect people from harm and in line with their individual needs outlined in their care plans.

We found people were not restricted in the freedom they were allowed and that they were protected from harm in a supportive respectful way. For example we spoke to people who preferred to stay in their room at all times, rather than be in communal areas, so staff provided increased monitoring to these people to ensure their safety whilst respecting their choices. Two people we spoke with who chose to stay in their rooms much of the time confirmed that staff came to them in a timely manner when they used their call bells and checked on them on a regular basis.

Staff were aware of the process for reporting accident and incidents. Records in regard to incidents allowed the person completing the document the opportunity to formally record any learning outcomes or changes to practice in the service that had occurred as a result of an incident, but this had not been utilised. The manager was able to verbally tell us of the learning following their most recent incident at the service. Staff told us that any changes to practice or learning from incidents were shared with them at daily handovers and staff meetings. This meant that on-going learning and subsequent improvements and developments within the service were happening but were not clearly documented.

Records we saw demonstrated that the provider had undertaken the appropriate pre-employment checks, that included references from previous employers and criminal records checks. We saw that there were sufficient numbers of staff to meet people's needs. We saw that people were responded to in a timely manner, including the answering of call bells and that staff were available for people to ask for assistance in communal areas. The manager told us that staffing levels were determined in line with peoples changing needs using a staffing guidelines tool. People and their relatives told us they had no concerns over staffing levels. One relative told us, "There are plenty of staff, all the time ". Disciplinary procedures within the service were reviewed. Records showed that the manager had taken appropriate action, investigated allegations and dealt with staff involved in line with the provider's policy, when incidents had arose.

Findings from our focussed inspection 18 May 2015

We found the provider had not taken appropriate action to improve and sustain how medicines were managed in order to meet the requirements of 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked in detail at nine medicine administration records (MAR) and found that people's medical conditions were not being treated appropriately by the use of their medicines. We found some of the MAR were not able to clearly demonstrate that people were getting their medicines at the frequency that their doctor had prescribed them; for example, one person had not received the correct dose of their inhaled medicines for an extended period of time. This person had needed urgent medical attention which may have been a contributory factor of their medicines not being administered as prescribed.

We saw that one person had been prescribed a short course of antibiotics by their doctor; it had been identified that this medicine interacted with one of their existing medicines and could lead to serious side effects. The course of action to prevent this interaction would be to stop the existing medicine for the period of time the antibiotic was taken, however the provider failed to do this. We spoke to the registered manager who said she was aware of the interaction between these two medicines. However, no measures had been put in place to ensure that staff stopped the person's one particular long term medicine to avoid the person experiencing any serious consequences. The registered manager told us she had not received any reports of the person experiencing any ill effects.

We reviewed the records for people who were having medicinal skin patches applied to their bodies; we found that records of where the patches were being applied were in order. However records showed that the application of the patches was not in accordance with the manufacturer's guidelines. The provider therefore was not able to

Inadequate

Is the service safe?

demonstrate that these patches were being applied safely and therefore could result in people experiencing unnecessary side effects; for example, by failing to rotate the patch to the stated number application of sites on the body, this could cause the persons skin properties to change leading to increased absorbency of the medicine, which in turn could leave the person feeling unnecessary pain.

Records we reviewed for medicines prescribed on an 'as required' basis did not contain sufficient guidance about how and when to administer these medicines in order to ensure that they were given in a timely and consistent way. The guidance for staff for one person who was prescribed as required medicine was to be administered when required for agitation in 'extreme circumstances'. Staff we spoke with were unable to tell what that meant to them or for the person concerned. We were unable to determine how often the person had been given this medicine, as records were incomplete and stock levels had not been checked.

People who chose to self-administer their medicines were not protected from any related risks. Records we reviewed failed to show that the potential risks around self-administration of medicines had been assessed. The provider was also unable to demonstrate they were monitoring the self-administration of these medicines to evidence that these medicines were being taken as prescribed.

People requiring medicines to be administered directly into their stomach via a tube, were not receiving them safely. The necessary guidance for staff in respect of medicines that were administered through this route was not in place. Staff confirmed to us that no guidance was available and that a pharmacist had not checked or approved their methods of administration. This meant that the provider had not ensured that the necessary safeguards were in place to ensure that these medicines were prepared and/or administered safely. We found that for people who may need their medicines administered by disguising them in food or drink the provider had not adopted the necessary measures to ensure that these medicines were being administered safely and in line with good practice. The meant that the administration process was not in line with the Human Rights Act 1998 or the Mental Capacity Act 2005.

Medicines were found to be stored securely and at the correct temperature, for the protection of the people who lived there. Those medicines requiring cool storage were being stored at the correct temperature and so would maintain their effectiveness.

This is a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Good

Is the service effective?

Our findings

(Text unchanged from comprehensive inspection)

Good

Is the service caring?

Our findings

(Text unchanged from comprehensive inspection)

Good

Is the service responsive?

Our findings

(Text unchanged from comprehensive inspection)

Requires Improvement

Is the service well-led?

Our findings

(Text unchanged from comprehensive inspection)

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 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	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines **30 October 2015** People were not protected against the risks associated with medicines because the provider did not have appropriate arrangements in place for the safe administration and recording of medicines.

This section is primarily information for the provider

Enforcement actions

The table below shows where legal requirements were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **18 May 2015** The provider had failed to protect people using the service against the risks associated with the unsafe use and management of medicines.

The enforcement action we took:
Issued a warning notice