Care Quality Commission

Oakland (Littlehampton) Limited

Oaklands Littlehampton Limited

Inspection report

Oakland Grange
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Ratings

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

Overall summary

This unannounced inspection took place on the 24 February 2015. Oakland Grange provides support and accommodation for up to 42 older people, some of whom were living with dementia. On the day we inspected 28 people were being accommodated.

The home has a 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.

Summary of findings

When we inspected the home on 26 November 2013 we found a breach of the regulations regarding the care and welfare of people and deemed this had a minor impact on people. The provider sent us an action plan and told us how they would address these concerns.

At this inspection, we noted that staff had an understanding of abuse and what action they should take if they felt someone was not receiving safe care. Staff knew there were safeguarding policies and procedures. Risk assessments relating to people were completed to promote people's independence. Staffing levels met the needs of people. Staff received training to ensure they could meet people's needs. Staffing recruitment records were complete and detailed all the necessary checks had been undertaken to ensure people were safe. The administration of medicines practices in the home were safe.

People felt staff had the knowledge to care for them effectively. Training was provided to ensure staff had the skills to meet people's needs. Staff received support but all did not receive regular formal supervision. Staff had awareness and understood the principles of the Mental Capacity Act 2005. People had their nutritional needs taken into account and there was a choice at all meal times. Health needs were assessed and the relevant professionals were involved in people's care provision.

Staff were kind, respectful and caring. People were involved in decisions about their care. Care plans were personalised and provided detailed information to guide staff about the support a person needed. People had no concerns or complaints about the home and felt able to speak to the manager if they did.

The registered manager operated an open door policy and welcomed feedback on any aspect of the service. Staff confirmed management were open and approachable.

Quality assurance in the form of auditing took place on a regular basis. Any learning from audits took place and this was reviewed to ensure it brought about effective change.

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?
The service was safe.

People were protected from avoidable harm by a staff team who had regular training and were aware of safeguarding policies and procedures.

Appropriate recruitment checks were completed on staff before they began working in the home.

Medicines were managed safely.

Good

Is the service effective?
The service was effective.

Staff had the training and skills to carry out their role effectively.

Consent was not assumed and staff understood the Mental Capacity Act 2005.

People had a choice at mealtimes and enjoyed their meals.

Good

Is the service caring?
The service was caring.

People were involved in the planning and delivery of their care.

People were treated with kindness and their privacy and dignity was respected.

Good

Is the service responsive?
The service was responsive.

People received care which was planned and responsive to their individual needs.

People felt confident to complain and were sure their complaint would be listened to.

Good

Is the service well-led?
The service was well led.

The manager monitored incidents and risks to make sure the care provided was safe and effective. Staff were supported by the home's management team.

There were systems in place to monitor the service offered and ensure there was learning from incidents and accidents

Good

Oaklands Littlehampton Limited

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 24 February 2015 and was unannounced. The inspection team consisted of one inspector, a specialist advisor and an expert by experience. The specialist advisor had specialist knowledge in the care of frail older people, especially people living with dementia and those with end of life care needs. 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 had experience of caring for people living with dementia.

Before the inspection, we reviewed previous inspection reports, action plans from the provider, and other information we had received including notifications. A notification is information about important events which the provider is required to tell us about by law.

Following the inspection we requested information from six health and social care professionals including district nurse and social work staff.

During the inspection we spent time talking to six people, 5 members of staff, the registered manager and a representative of the service provider, the director. We looked at the staffing records of four members of staff. We were shown a copy of the appraisal overview, and the training matrix for the current and previous year. We were given copies of four weeks of duty rotas for all staff. We saw minutes of staff meetings, residents meetings, the policies and procedures file, and quality audits from an external professional, the accident and incidents folder, the complaints log and records of audits.

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 observed interactions between people and staff.

Good

Is the service safe?

Our findings

All people and relatives we spoke with told us the home was a safe place to be. “I’ve felt as safe as ever, it’s very secure” and “This place is very good” were comments from people when asked if they felt safe. People felt they were encouraged to be independent. Three people commented You are free to do as you please”, and, “I can move around on my own but I have to be careful”, and, “I have the choice to be where I like”, People told us there were adequate staffing levels; “I think there are enough staff about” and “There are enough staff”. People were satisfied with medication procedures; one person told us, “I get my drugs when I expect it”.

People were treated in a respectful manner. Call bells were answered quickly. Staff were aware of the core values of privacy, dignity and choice. Staff were seen to offer and uphold these values when working with people. Staff had an understanding of the different types of abuse and what action they would take if they felt people were not safe. People felt safe and told us if they had any concerns they would report these to the management team. People told us staff worked well with some people who they described as being more challenging, one person stated, and “The staff handle difficult people ok”.

Risk assessments where appropriate were included in people’s records. These enabled people to take risks and promoted their independence. The registered manager and director were aware of safeguarding policies and procedures. They had recently worked with the local safeguarding team to ensure the safety of people. As a result of this they had looked at their own quality audits and made improvements, for example in the recording of finances. Risk assessments were carried out on the building and there were clear procedures to be followed in the case of emergencies such as fire, power failure, water leakage and a gas leak, which staff showed an awareness of.,

No formal system or tool was in place to plan the staffing levels. These levels were assessed by the registered manager and provider on a regular basis and by talking to staff and people. The director did inform us they had found and were going to start to use a formal planning tool with regards to staffing levels. Most people felt there was adequate staff to meet their needs although one person did comment, “There’s little interaction with staff and not enough around”. Staff were encouraged to attend training and increase their skills and knowledge. The training matrix detailed what training staff had undertaken and when this was due for renewal. Staffing recruitment files demonstrated all necessary checks were undertaken on staff to ensure people were protected.

There was a comprehensive medicines policy and procedure. There was also a homely remedy policy. The medicines trolleys were clean and tidy, locked and secured. Medicines were stored securely. There was a disposal procedure and record, with a small amount of medicines to be disposed of. Each person had a photograph in the MAR (medicines administration record) folder and there was a list of people’s medicines including what it was for, the dose, frequency, and any changes were documented. Allergies were highlighted. Several people were prescribed medicine for congestive heart failure and it was confirmed that people’s pulse rate were recorded as this is necessary for this type of medicine. Once weekly medicines were highlighted on the MAR chart. The medicines round was observed and this was performed appropriately and safely.

Good

Is the service effective?

Our findings

One person said, “Staff seem OK at their jobs” when we asked if they felt staff were skilled. People gave us positive comments when talking about the skills of the staff. People told us they enjoyed their meals and were given a choice. “We get a choice the day before, two courses and a pudding, we can order something different”. Another person told us, “I am diabetic and they know this”. Another person told us, “We have sherry every day before lunch” and one person said, “Apart from not getting a whiskey, the food is marvellous”. A visitor told us, “No one ever complains about the food”. People told us they could access healthcare services, “I can see the doctor and a chap comes round to look at my toenails” and “There is a hairdressing salon here but the men are encouraged to go out for their haircuts”.

Staff received a good induction process, which provided them with the skills and learning required for their role. Annual appraisals were taking place and we could see some had already been completed; there was a list of when the remainder would take place. The manager had a system for supervision but not all staff received regular supervision. Staff reported they felt supported in their role and were not concerned by the lack of formal supervision. The manager did regular ad hoc supervision sessions which were recorded and signed by both parties involved. The manager kept good records where there had been issues raised and as a result staff had needed extra support. There were good lines of communication between the staff group as a whole, with regular meetings for groups of staff and the staff group as a whole.

Staff had received training on the Mental Capacity 2005 (MCA) and the provider had a comprehensive MCA policy. The MCA is related to testing people’s capacity to make certain decisions at a specific time. When people are deemed not to have capacity to make a decision, a best interests decision should be made with the people who know the person best including professionals. Staff had knowledge of the MCA 2005 and its principles and knew how to apply the training when working with people. People had ‘consent to care and treatment’ and ‘mental capacity assessment’ forms in their records. The assessment recorded if the person had capacity to make decisions about their care at the current time. If they did not have capacity there was a procedure to follow which included a best interests meeting and decisions to be made. Staff were aware of this policy.

People’s care records included information relating to people’s nutritional needs. These gave clear guidance on the needs of people and how they should be supported. One person’s records identified they, ‘Had a very poor appetite and needed prompting to eat their meals’. In February 2015 it was noted, ‘The resident continues to lose weight, GP is aware and the resident is to have build up and fortified drinks and forti-juice’. A nutritional risk assessment and a nutrition plan had been put in place. The person had been seen by the dementia matron, an external health professional, who had recommended drinks from a coloured beaker, which was to facilitate the person recognising the beaker in order for them to drink independently and this had been implemented. Staff were aware of this person’s nutritional needs and how to support them.

People had access to a range of health and social care professionals. There were notes which recorded when people had been seen by the GP or if the staff had discussed the person with the GP. There were notes of the district nurse involvement with people and treatment plans. Details were recorded of one person having a recent CT scan and a memory assessment. Steps had been taken when people became confused to see if they had an infection which could be the underlying cause.

Good

Is the service caring?

Our findings

People said, “The staff are very good, I can’t find fault with them” and “The carers are particularly nice here”, and “It’s a very happy home” One person said when we asked if they felt well cared for, “Yes, I have a care plan,” A relative told us, “There is a care plan and they do talk to me about Mum’s care”. People felt involved in the planning of their care. People told us their privacy and dignity was respected. “They always knock on my door” was a quote from one person.

People were treated with kindness and compassion. There was good communication between staff and people and staff were knowledgeable about people’s preferences. Staff spoke positively about and to people. One member of staff was overheard saying to a person, ‘you look glamorous'. Staff had a good knowledge of people as individuals. In all but one care plan staff had completed a booklet on people’s personal histories which included lists of their likes/dislikes and their preferences.

People were consulted over their care and were involved in daily decisions about their care and treatment. People were consulted on every day decisions, for example if they wanted the windows open in the conservatory, and what music they wished to listen to. People and families were involved in the planning and delivery of care Their wishes and choices had been taken into account and were recorded. There was good communication with people’s families, for example regarding clinic appointments and on-going health issues. Care delivered was of a kind and sensitive nature and people had their care explained to them where necessary.

People were treated with dignity and their privacy was respected. Staff were observed to assist people in a kind and respectful manner. People’s independence was promoted. People were encouraged to walk around the gardens with staff supporting people to wear warm clothes when outside. Staff understood the need to respect people’s confidentiality and understood not to discuss issues in public or disclose information to people who did not need to know. Any information that needed to be passed on about people was passed verbally in private or put in each individual’s care notes.

Good

Is the service responsive?

Our findings

One person said, “The care I need is given” and “There’s enough to do if you’re interested in joining in with the activities”; they felt the care they received was responsive to their needs. This was reflective of the comments received from all people and relatives we spoke with. People felt they could complain and would be listened to. “I’ve never complained, but sometimes there is a slight communication problem, there are residents’ meetings, every so often they will try and sort things out”.

Pre admission assessments were carried out before people moved into the home. This gave staff some information on the person, their support needs and how staff should provide support. Following this, an assessment was completed once the person had moved into the home. Assessments were personalised and included information pertinent to the individual. Personal safety and risk assessments and plans were in place. For example window restrictors had been used in one person’s bedroom. It was clearly documented the risks had been explained to the person and their family members.

Care plans were developed following the assessment. These were relevant to each person and included such areas as needs for washing, dressing, oral care, eye care, hearing, continence, mobility, sleeping, and likes and dislikes. We found these were individual to each person. For example, in the pre-admission assessment of one person it highlighted the person was at high risk of falls.

The mobility assessment identified a reduction in mobility due to dementia. Staff were pointed to the falls risk assessment, which identified one-to-one care in the evening to prevent falls and a requirement for assistance by two members of staff. A risk assessment had been competed as the person was identified as being at high risk of developing pressure ulcers as they were spending more time in their bedroom on their chair or bed. A specific nursing bed and mattress had been provided to reduce the risk and they were monitored by staff and weekly by the district nurse.

Care plans were reviewed monthly and there was a monthly well-being record which included monthly checks on falls risk assessments, a Malnutrition Universal Screening Tool (MUST), and a waterlow score (a risk assessment for the development of pressure ulcers). Where a person had a fall it was noted the fall was well documented on a visual body map and an open wound assessment chart had been completed and reviewed.

Activities records were included in people’s records. A monthly activities calendar was available and produced each month. On the day of our visit activities were provided by an outside entertainer who knew each person well.

There was an effective complaints procedure and complaints were recorded in a complaints log. We were able to see these were responded to within reasonable time scales. People, relatives and staff all felt able to raise any concerns or complaints with the manager. They felt confident the manager would take their concerns seriously.

Good

Is the service well-led?

Our findings

People told us they felt part of the home and were involved in the decision making around the home. One person said, “They do listen and I think they would sort it out” Some people were unsure who the manager was but knew the director and felt they could talk to them. “The manager is not around much” and “This is a warm and friendly place, we see the director more than the manager” were quotes by people and relatives.

We saw lots of engagement between people and staff. Staff would regularly try and involve people in day to day decisions. The home had regular residents meetings where people’s views were recorded. Each meeting followed up the issues raised at the last meeting. Staff meetings were also arranged which gave staff the chance to raise any concerns. The minutes reflected staff could raise any issues of concern. Staff and residents questionnaires had recently been completed. The results of these had been analysed and where necessary an action plan had been put in place to bring about changes.

Staff could recall the key values of dignity, respect and privacy, but were uncertain if these were their own values or the values of the organisation. These core values were also part of the homes induction process.

The home has had a registered manager in post for over twelve months. We received a mixed picture of the management of the home. Most people spoken with were not sure who the registered manager was and referred to the director as the person in charge. However they felt the director was a good manager and always available to discuss any concerns. Staff were aware of who the registered manager was and reported they felt part of a team. One staff member told us, “She is always available when needed, and will come in and help if needed”. Another told us they felt the manager was a good listener. Staff told us the management of the home had an open door policy and they felt they could discuss concerns or improvements with the registered manager. The senior staff meeting minutes of January 2015 recalled that, ‘management was not always available and could come across as snappy’. There was no recorded action against this point.

The home had a policy and procedure for quality assurance and audits took place regularly. The director carried out a monthly audit which looked at eleven areas of the home’s overall performance. A weekly medicines audit with comments on controlled drugs stock checks, MAR charts, fridge and drug medicines cupboard storage temperature checks, and medicine cupboard cleaning records, PRN (as required medicines) protocols, returned medicines and self-medication review for those who were being supported to administer their own medicine.

The registered manager had introduced an ‘Employee of the month scheme’ which recognised staff who were working towards excellence. Accidents and incidents were logged and these were analysed to look to see if there could be any learning from these events. We discussed with the registered manager ways the analysis could be improved to look for emerging patterns.

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.

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.