Select Health Care Limited

Oak Bungalow

Inspection report

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Tel: 01603868953

Date of inspection visit:
16 January 2019

Date of publication:
26 February 2019

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

What life is like for people using this service:
•□Risks to people were not always thoroughly assessed and mitigated.
•□There was some inconsistency around care planning, risk assessment and recording of medicines.
•□Staff did not always support people to communicate and interact according to their needs in a caring way.
•□Care plans were not always accurate and up to date.
•□Care was not always person-centred.
•□Governance systems did not always identify areas for improvement and action was not always taken.
•□There were enough staff and they were recruited safely.

Rating at last inspection: 'Good' overall, and in effective, caring, responsive and well-led, with 'Requires Improvement' in safe - (published 12 July 2016).

About the service: Oak Bungalow is a care home with nursing for up to six people. There was a manager who is registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the services are run and for the quality and safety of the care provided.

Why we inspected: We inspected this service in line with our inspection schedule for services currently rated Good.

Follow up: We will continue to monitor this service according to our inspection schedule.

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.

Oak Bungalow

Detailed findings

Background to this inspection

The 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 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.

Inspection team: The inspection was carried out by two inspectors.

Service and service type
Oak Bungalow is a care home providing accommodation and nursing care for up to six people with physical disabilities and neurological conditions. They also provide rehabilitation. CQC regulates both the premises and the care provided, and both were looked at during this inspection. There were six people living in the home at the time of our inspection. The service had a manager registered with the Care Quality Commission.

Notice of inspection
The inspection was unannounced.

What we did:
We reviewed information we had received about the service since the last inspection. This included details about incidents the provider must notify us about, and we sought feedback from the local authority and professionals who work with the service. We used all this information to plan our inspection.

During the inspection we spoke with three people to ask about the experience of living in the service. We also spoke with three relatives, one who had not yet visited the service as their family member had recently moved in. The further two relatives who were visiting one person. We looked at three care plans in detail and the medicines administration records (MARs). We discussed the manager's quality assurance processes and audits and reviewed some of these, for example health and safety records and medicines audits.

As well as the registered manager, we spoke with four further members of staff including two senior carers, a

registered nurse, and the care co-ordinator. We gained feedback from a healthcare professional who was involved with the service.

Requires Improvement

Is the service safe?

Our findings

Safe – this means people were protected from abuse and avoidable harm.

At our last inspection on 2nd June 2016, this key question was rated, 'Requires Improvement.' This was because we found that the environment was not always safe. At this inspection, we found the service had not improved sufficiently and continued to be rated, 'Requires Improvement' in safe.

Requires Improvement: 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.

Assessing risk, safety monitoring and management
• There were areas where risks to people's health were not identified and action not taken. For example, we saw one person's oral hygiene care plan which stated, 'none known' for dentist visits in November 2017. The care plan had no further exploration of this and the person had lived in the service for many years. There was no further evidence of the service supporting any dentist visits. There was a later record in March 2018 that the person had an abscess. There were no further records after this point which evidenced a dentist had been sought to review the person's oral and dental health. There were no risk assessments in place to guide staff on how to support the person to mitigate risks associated with oral health.
• Some risks to people continued to be assessed and were managed safely, for example, risks associated with manual handling.
• We saw that the management team and the provider monitored the safety of the service and continued to ensure the home environment was kept safe for people, for example with regard to fire safety, water safety and lifting equipment.

Using medicines safely
• The recording of medicines administered was inconsistent. This meant it was not always clear if staff were aware of what items the person was self-medicating, and if they were administering additional prescribed creams or not. Risk assessments for people self-medicating had not been filled in properly, for example, questions such as whether the person was able to open a bottle independently, had not been answered. Therefore, it was not clear whether these questions had been considered.
• There were protocols in place when needed for medicines prescribed 'as required' (PRN), to guide staff on how and when to administer these. Medicines were stored and disposed of correctly and there were management processes in place to ensure staff were competent to administer people's prescribed medicines.

Systems and processes
• People continued to be safe and protected from avoidable harm. People told us they felt safe. Staff demonstrated an awareness of safeguarding procedures and knew what constituted abuse, and how to report any concerns. The registered manager was aware of their responsibility to liaise with the local authority safeguarding team if concerns were raised.

Staffing levels

• People told us consistently that there were enough staff. The registered manager confirmed that they continued to carry out necessary checks to ensure staff and volunteers were suitable to work with people. These included checks of references and the Disclosure and Barring Service, a national agency that keeps records of criminal convictions. These checks assist employers in making safer recruitment decisions.

Preventing and controlling infection

• Staff completed training in infection control and used the relevant personal protective equipment, such as gloves and aprons appropriately. The home was clean.

Learning lessons when things go wrong

• The management team learned from individual incidents. There were systems in place to monitor and learn from accidents and incidents. When an incident occurred, for example, around someone going out into the community independently, the incident was discussed with the person and risks were reviewed.

Requires Improvement

Is the service effective?

Our findings

Effective – this means 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.

Adapting service, design, decoration to meet people's needs
• There was a communal lounge and small dining area in the home. However, the communal areas were not all designed around people's needs. There was not space for everyone to sit and eat in the dining area if they wished to. However, nobody reported this as a problem. People did not always have access to the communal lounge as this was often used for staff training and not centred around people's needs. There was a corner of the lounge used for storage of old equipment and boxes. People's individual bedrooms were large and bright, and they had accessible en-suite showers. There was a communal kitchen, and people were able to use this with support from staff. There was also a bedsit which one person was living in, which enabled them to have more independence.
Supporting people to eat and drink enough with choice in a balanced diet
• We observed that people were offered drinks frequently. We had mixed feedback about the food in the home as two people said they did not always like the meals. For one person, this was because meals were reheated in the microwave. We saw records of menu choices and saw people were offered a choice of three meals at lunch, and different soups and sandwiches for tea.

Staff providing consistent, effective, timely care
• The service had some systems and processes for referring people to external agencies and ensuring they could access healthcare. There were also a range of qualified healthcare professionals involved in people's care as part of the provider's organisation. This included occupational therapy and physiotherapy, as well as access to a psychologist. However, improvement was needed in some areas to ensure people had the opportunity to access and attend check-ups, such as dental appointments.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
• People's needs were comprehensively assessed with appropriate health and social care professionals involved.

Staff skills, knowledge and experience
• Staff were competent, and people and relatives felt they knew how to care for people.
• There was a comprehensive induction process for new staff.

Ensuring consent to care and treatment in line with law and guidance
• The Mental Capacity Act 2005 (MCA) provides a legal framework for making 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 decision and are helped to do so when needed. When they lack mental capacity to make

decisions, any made on their behalf must 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).

• Staff ensured people were involved in decisions about their care and asked for consent.

Requires Improvement

Is the service caring?

Our findings

Caring – this means 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
• In the main, people and their relatives told us most staff were kind and caring when interacting with them. One person said they had a laugh with staff. However, they added, "Not all staff will bother." Staff did not always support people to communicate according to their needs. Another person said some staff spent time on their mobile phones and this put a stop to conversation. One relative said that staff did not always pay attention to detail and care could be task-focussed. This meant the relative often noticed minor issues and had to address them with staff as they hadn't already been identified.

Supporting people to express their views and be involved in making decisions about their care
• We saw from records that family members were contacted appropriately by staff, for example if there was an incident or change in someone's health. However, staff did not always proactively ask people for feedback. We did not see evidence in people's care plans that they had been involved and regularly consulted about their care.
• Where the provider made decisions about the home, there was no evidence that people were involved in these.

Respecting and promoting people's privacy, dignity and independence
• We saw that in some instances, staff supported people to become more independent. For example, they were supporting one person to make their meals on a regular basis. They supported another person to walk down to the local shop and have a lift back. This meant people were encouraged to increase their mobility and daily living skills. However, one person told us about things they enjoyed doing, such as cooking, and they were no longer supported to do this. Staff told us this was because the person no longer showed interest in these activities, however it had not been thoroughly explored with the person and this had not been recorded.

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means that services met people's needs.

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

How people's needs are met

Personalised care
• Care was not always personalised to individual needs. Care plans were not always in place for relevant aspects of people's lives or their health conditions, for example, supporting people with depression. Where people had expressed support needs around sexuality and relationships, these had not been explored, supported or planned for.
• Where there were care plans in place for specific support, staff did not always follow these. There was no evidence as to what action had been taken to further explore people's needs or why care plans were not followed.
• Care plans were not always kept up to date and reviewed properly. We saw that some had been reviewed and staff had written, 'no change' despite this being inaccurate as people's needs had changed.
• People engaged in activities either in the provider's other home on the same site and some went out in the community independently. However, there was no evidence that activities were provided in the home for people according to their specific needs and interests. One person told us about their interests which included playing games and staff did engage with them when they had time, but there was no specific plan for this. They additionally told us about their other interests, and we saw no evidence that these were supported. Another person, who was new to the service, told us the activities provided in the other home which they had been offered, did not meet their needs.
• People did not always have access to the communal lounge because it was used for staff training. A member of staff said at times this affected people's anxiety levels and made them feel uncomfortable in their home. Relatives also told us it often meant they did not have a space to spend time with their family member.
The lack of personalised care provided according to people's individual needs and preferences meant there was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Improving care quality in response to complaints or concerns
• The registered manager had investigated any complaints or concerns bought to their attention. Most relatives and people we spoke with said they would approach staff or management if they had any concerns. However, they were not proactively asked for feedback regularly.

End of life care and support
• The service provided some staff with training in the six steps end of life programme, which equipped them for following best practice. Not everybody using the service wanted to engage in this part of their longer-term care planning, however staff had addressed it with people. We saw one person's 'thinking ahead' care plan and this contained important details around the person's end of life wishes.

Requires Improvement

Is the service well-led?

Our findings

Well-Led – this means 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.

Leadership and management; Engaging and involving people using the service, the public and staff; Managers and staff are clear about their roles, and understand quality performance, risks and regulatory requirements
Provider plans and promotes person-centred, high-quality care and support, and understands and acts on duty of candour responsibility when things go wrong
• There was not always evidence that the culture of the service encompassed person-centred care. Management systems did not always promote and maintain a caring culture within the home. This was because care plans, care delivered, and people's environment was not always reflective of individual needs and preferences. We spoke with three people living in the service and all gave us some negative feedback.
• There was no effective system in place whereby staff checked with people regularly that their needs were being met. All the people and relatives we spoke with confirmed to us that they had not been asked for feedback. One relative pointed out that the 'named nurse' role is not effective as there is not a specific member of staff overseeing the people's care. This opinion was further reflected by a staff member.
• Systems in place which checked and monitored the quality of the service were not always effective. There were audits of care records, medicines and health and safety checks. Checks were carried out by the management team as well as the provider's organisation. However, governance systems required improvement. Medicines audits had not identified errors in the documentation, risk assessing and care planning. Agreed spot checks and reviews to monitor one person's self-medicating had not been carried out. There were not always thorough care plans in place and contemporaneous records to support people's complex care requirements. A thorough medicines audit which included records around administration and management had only been completed for one person living in the service.
The lack of robust quality assurance meant that people were at risk of receiving poor quality care, and a decline in the service quality was not identified by the provider. This meant there was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

• Staff attended meetings and shared information through a handover process. People's changing needs were verbally communicated between staff. All staff we spoke with said they could go to the registered manager at any time with concerns or if they required support.
• There was an awareness of the duty of candour and the registered manager was aware of their responsibility. This means that services must open and honest with people when something that goes wrong with their treatment.
• Staff felt supported by the management team.

Continuous learning and improving care

• The service was working on some improvement plans. The provider was rolling out a plan to rewrite the care plans in a more person-centred manner.

Working in partnership with others

• The service worked in partnership with other organisations to ensure they were following current practice guidelines. These included healthcare professionals such as social workers and GPs.

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 Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care People did not always receive care according to their individual needs 9 (1) (a) (b) (c) (2) (3) (a) (b) and (c)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to implement systems and processes that effectively assess, monitor and determine risks to people or maintain accurate, complete up to date records. The provider had not always sought and acted on feedback. 17(1), (2) (a) (b) (c) (e) and (f)