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

Overall summary

This unannounced inspection took place 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.

Oaklands Care Home is registered to provide accommodation, nursing or personal care for up to 60 people. People may have a range of needs which include physical and mental health needs and old age. Whilst most people live there permanently the service also provides care to people on a short term rehabilitation basis including respite stays. Respite means that a person may need to be cared for away from their home for a short period of time due to changes in their social circumstances or health needs. At the time of our visit 37 people were using the service. The service is registered to provide accommodation for 60 people; however accommodation was only available for use for 40 people.

The service had a registered manager. 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.

Summary of findings

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.

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 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.

Requires Improvement

Is the service effective?
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.

Good

Is the service caring?
The service was caring.

People were complimentary about the staff and the care they received. We observed staff interacting with people in a kind and compassionate manner.

Although people's religious needs were routinely considered staff did not consider a more diverse range of needs, for example sexuality as part of a personalised assessment.

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

Good

Is the service responsive?
The service was responsive.

People had been involved in their care planning and reviews of their content took place on a regular basis. Relative's involvement in this process was evident. This meant that people were involved in directing and making decisions about the care they received.

The provider had a complaints procedure in place. People and their relatives told us they knew how to make a complaint and felt confident that the manager would deal with any issues they raised.

Good

Summary of findings

Is the service well-led?

The service was not always well led.

People, relatives and visiting professionals spoke positively about the approachable nature and leadership skills of the registered manager.

Support received by the registered manager from the provider lacked structure, including emergency out of hour's cover for the service.

The provider needed to be more consistent in notifying us of serious incidents that had occurred within the service.

Quality assurance systems including feedback from a variety of users and stakeholders of the service were used to improve people's experience of the service to ensure that it was operated in their best interests.

Requires Improvement

Oaklands Care Home

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 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.

Requires Improvement

Is the service safe?

Our findings

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".

Requires Improvement

Is the service safe?

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 ongoing 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.

Good

Is the service effective?

Our findings

We spoke with staff about how they were supported to develop their skills to meet people's needs effectively. Staff told us they received regular training in areas that were appropriate to the people they care for. For example, staff had received equality and diversity training and the staff we met with identified individuals using the service that had specific needs in regard to their religious beliefs; outlining the support they received from a variety of the local religious groups to meet these needs.

Staff were complimentary about the training provided. People we spoke with told us that they felt safe being cared for by the staff and they believed them to be well trained. One staff member said, "The training is good, if you don't understand you can ask". Staff told us they discussed their training needs with the manager and planned future training in their annual appraisal. Records showed that some staff were not up to date with their mandatory training. The manager provided us with evidence that arrangements had been made for these staff to attend the appropriate training sessions in the coming weeks to ensure their knowledge was brought up to date. We saw that in addition to mandatory training a number of staff were completing training linked to the Qualification and Credit Framework (QCF) in health and social care to enable them to look after people safely and in the way that they preferred. The manager told us that all staff, upon completion of their induction were encouraged to undertake further training of this kind. One health care professional told us that in regard to training and development they found the manager to be proactive and supportive of staff.

We saw that staff had bi monthly individual supervision sessions; these were focussed on specific relevant topics, for example documentation and manual handling. The manager told us these meetings supported them to ensure that staff had a good level of knowledge in key areas that have a direct impact upon people's wellbeing. Staff told us that they received regular supervision and felt this was of value to their ongoing development. One staff member told us, "The seniors check on everything we do".

We joined the staff for their handover meeting between shifts. Communication was clear to the oncoming staff for the next shift in regard to any changes in people's health and wellbeing. The information discussed was documented for staff to refer back to, with key issues and concerns clearly highlighted. This meant that staff had up to date information to meet the specific needs of people they cared for.

Staff we spoke with had received training in the Mental Capacity Act (MCA) 2005 and Deprivation of Liberties Safeguards (DoLS). DoLS is a legal framework that may need to be applied to people in care settings who lack capacity and may need to be deprived of their liberty in their own best interests to protect them from harm and/or injury. Staff told us when people were not able to give verbal consent they would talk to the person's relatives or friend to get information about their preferences. The manager told us they were confident staff would recognise people's lack of capacity so best interest meetings could be arranged. Records showed that people's mental capacity had been considered as part of their initial assessment with review dates in place for those people where a level of cognitive impairment had been identified. The manager had a good understanding of DoLS and knew the correct procedures to follow to ensure people's rights were protected. At the time of our visit no one using the service was deprived of their liberty.

We observed lunch being provided and saw that people were supported at mealtimes to access and make choices about the food and drink they consumed. Staff told us they had received training in food hygiene and were aware of safe food handling. Menus were displayed with a variety of choices available. One person told us, "The chef is fantastic". Another said," There is always a good choice of food". We saw that people's views had been sought through a questionnaire about their likes and dislikes and their views had been used in planning the menu. Meals were nutritionally balanced and appetising, with extra portions freely offered to people. Drinks were available to people throughout the day; drinks were within their reach during our visit. People told us drinks are always available to them from the trolley that comes round regularly or that they can ask staff at any time. People told us they enjoyed the food the provided and we saw that the event was relaxed and informal.

The chef told us that any specific dietary needs or changes to people's nutritional needs were communicated to them by nursing staff on a daily basis. Staff we spoke with knew which people were nutritionally at risk and those who needed their fluid intake to be monitored. People who

Good

Is the service effective?

chose to have meals in their rooms and people who required assistance from staff received their meal in an effective and timely manner. This showed us the service was able to meet people's individual needs in respect of nutrition.

People were supported to maintain good health. A General Practitioner (GP) visited weekly and reviewed people under direction of the nursing staff as necessary. People told us that they saw a doctor when they needed to and that staff involved them in addressing their health care needs. We saw examples in care records of staff accessing more urgent reviews by a doctor in response to people's changing health needs. Records showed regular access to dentists and chiropodists was routinely provided. We saw that a range of healthcare professionals such as district nurses, Macmillan nurses, dieticians and physiotherapists provided regular specialist input for people who lived there. One professional told us that medical attention had been sought quickly by nursing staff when people's health needs changed.

Good

Is the service caring?

Our findings

People spoke highly about the caring and respectful attitude of staff. One person told us, “Staff are very caring”. A second person said, “You can ask for anything you want”. A relative told us, “Staff are compassionate ". Another relative told us, "This is the best home in the area and I would be happy for any of my friends and family to be here". We observed kindness and compassion displayed by staff when interacting with people. For example, we saw one person was feeling anxious so a staff member held their hand and talked to them in a calming manner; it was evident that the person responded well to such reassurance. Through our discussions and observations on the day of our visit, we confirmed that people’s preferences and wishes were understood and respected by staff. One person told us, “I get help whenever I need it, how I want it done”. We saw that staff encouraged people to remain independent through asking them what support they needed and how they would like tasks to be undertaken. People told us that staff respected their privacy when assisting them and would encourage them to try to do as much for themselves as possible, but were there to support them when they needed help.

People’s cultural needs were routinely considered, for example we saw that representatives of local religious establishments visited regularly or were asked to visit people at their request. Holy Communion was provided on a fortnightly basis for people to access on site.

We saw that people were provided with information about the service. People told us that they had found the ‘Service User Guide’ located in their bedroom useful in the first few days after their arrival. The manager told us that other formats of the document were available to meet people’s communication needs. The guide covered a range of health and safety issues, information about meals and meal times, support available to people whilst using the service including visiting professionals role in their care, local community services that were accessible, activities, care plans and the key worker role.

Staff demonstrated they knew each person’s individual likes and dislikes and supported them to make choices in a dignified manner. We saw that people were allocated a key worker on admission to the service; they were a point of contact for people, encouraging continuity of staff they were supported by. People we spoke with understood who their key worker was but were clear that they could also approach any member of staff at any time if they needed support.

Staff we spoke to were not clear about how they would access advocacy services for people, as such an instance had not occurred. The manager told us they had not needed to access advocacy for people using the service to date. Information was not routinely available to people in regard to local advocacy contacts, but was kept in a folder in the manager’s office. This meant that people may not have easily accessible information they require in regard to independent advice and support.

Good

Is the service responsive?

Our findings

People were involved in all aspects of their own care planning. One person told us, “I am kept informed of everything that is planned for me”. A relative told us,” "Yes I have been involved in reviewing mum's care, I agreed that every three months is fine but it could be done every month if I wanted". Records showed assessments were completed to identify people’s support needs.

Care plans contained personalised information detailing how people’s needs should be met. They included information about their health needs, personal preferences and life history, in the form of a “Map of Life” document. Personal preferences included important instructions for each individual, for example one person preferred to leave their curtains closed and bedside lamp on at night. Another had requested female carers only to provide personal care; staff confirmed that they were aware of this preference which they planned for accordingly. People’s rooms had been personalised to reflect their family history and displayed items that were of sentimental value or of interest to them. Care plans had been regularly reviewed and updated.

During our visit a number of people were involved in activities that were provided by the provider’s part time hobby therapist and a visiting musician. We observed that people were animated and clearly enjoying the activities. A series of planned activities were available within the service for people in groups or on an individual basis, based upon their preferences and personal history. People told us that activities were on offer throughout the week at various times. One relative said, “There are plenty of activities for mum". A second relative told us, “Mum is always offered activities but she usually says no".

Residents meetings were regularly held; subjects discussed included activity planning, the environment and plans for upcoming events. The manager made available a book for people and their relatives to make comments about their experience of the service in, which was accessible to people in the reception area. We saw entries in the book which were very complimentary about the service; 14 had been recorded in the past four months. This showed that people and their relatives had a variety of ways to share their experiences and concerns about the service.

Concerns and complaints about the service were encouraged and responded to. Information about how to make a complaint about the service was in an accessible area and also outlined in the service user guide. The service user guide was a booklet for people to read and refer to which gave a wealth of information about service. People we spoke with knew how to complain. One relative told us, “I have no qualms at all about complaining”. One person using the service said, “I have no complaints, I am happy here". People told us they would in the first instance speak to the manager and felt their concerns would be listened to and acted upon. No one we spoke with had had cause to complain. No complaints had been received by the service since our last inspection in June 2014.

Requires Improvement

Is the service well-led?

Our findings

People we spoke with told us the manager was accessible and approachable and they felt able to speak to them openly. People using the service were very positive about the manager and nursing staff. One person using the service told us," The manager is great". Staff we spoke with told us, "The manager always makes time to listen to us". During our inspection we saw that there was a positive warm relationship between the manager, staff, people and their relatives. One staff member said, "The manager is approachable and friendly". Compliments were recorded and relatives praised the manager on the quality of care provided and several stated they would recommend the service to others. The manager has been in their role for many years in the service and spoke passionately about their role in providing people with a quality service.

We spoke to the manager about how they considered people's diverse needs. We saw in records that people's needs were considered in regard only to their religious needs. The manager told us that they did not feel comfortable in asking questions about people's more specific diverse needs, for example people who may be from the lesbian, gay, bisexual or transgender community. All aspects of a person's life including the non-visible differences that exist between people should be considered as part of a comprehensive assessment of people's needs. This meant that the manager was not leading by example to promote a personalised and inclusive assessment of people's needs.

Learning was outlined by the manager and staff from incidents and accidents. Records of incidents were appropriately recorded. For example, following a recent incident the learning in relation to this had been to improve practices in respect of clinical decision making by incorporating a tool for the assessment of pain. Nursing staff were aware of the learning and changes to practice following this incident. This meant that learning from incidents had enabled improvements to promote people's safety had been made.

Staff met regularly with the manager and elements of good practice were discussed and shared. This provided assurances to the manager that learning was embedded within staff practices. Staff told us that feedback from the manager about their performance and discussing their development needs made them feel valued and helped them to understand their roles and responsibilities. One staff member told us, "I am given time to discuss my training needs but can see the manager at any time to ask about other training".

The manager told us they received "ad hoc" support from the provider and found the directors to be supportive. The manager told us no supervision to develop their management or professional roles were on offer from the provider. Cover arrangements for the service were the registered manager's responsibility. The manager stated that nurses did call them for advice and reassurance on a regular basis. Staff we spoke with were clear about the arrangements for who to contact in an emergency.

The registration details that we hold for the provider state that they are able to provide accommodation for 60 people. During our inspection we were shown that 20 of the beds were not in use. These 20 beds were situated in a separate area away from the 40 beds the manager advised were used regularly. We saw that the rooms were not fit for purpose and in need of major refurbishment to provide suitable accommodation that was safe for people to use. The provider agreed to submit a variation to their registration with CQC in order to give an accurate reflection of bed availability.

The manager had failed to consistently notify us of incidents which had occurred within the service. One incident we saw documented which had resulted in disciplinary action against staff members had not been shared with us. The provider is required by law to notify CQC of serious incidents that have happened in the home.

The manager told us that they periodically performed "spot checks" including weekend visits. Staff we spoke with confirmed that the manager completed unannounced spot checks. One NHS healthcare professional who provided regular input to the service commented that the manager kept a close eye on the general wellbeing of the residents and the attentiveness of staff to people's needs.

Processes were in place to monitor the systems and practice in the service to assess the quality of the service. People and their relatives said they were asked for their feedback about the service. We saw that periodically people and their relatives were encouraged to participate

Requires Improvement

Is the service well-led?

in residents meetings. The meetings sought to share information and seek people's opinions. Feedback from people using the service, relative surveys, and stakeholder questionnaires formed part of this process.

Monthly audits were completed by the manager that included medicine management, infection control, accidents, equipment and health and safety in the environment. We saw that actions were taken where quality or safety was identified as an issue as a result of these checks. Audits in respect of medicines were undertaken on a monthly basis, which included checking for gaps in medicine administration records. However we found gaps in medicine administration records which meant these audits were not robust.

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 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.