Care Quality Commission

Mrs Wendy Kwong

Oakapple Care Home

Inspection report

Debdale Bungalow
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Mansfield
Nottinghamshire
NG19 7EZ
Tel: 01623 622588
Website: none

Date of inspection visit: 19 March 2015
Date of publication: 19/08/2015

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**

Overall summary

This inspection took place on 19 March 2015 and was unannounced. There were breaches of legal requirements at our last inspection in 2014 and we had been assured by the provider that improvements were made. During this inspection we found there were still further improvements for the provider to make.

Oakapple Care Home provides care and accommodation for up to ten older people in a mixture of single and double bedrooms. There were eight people receiving a service when we visited. All the accommodation was on one floor. There were accessible garden areas and car parking was provided for visitors.

There was a manager, but she had not updated her registration with the Care Quality Commission since the implementation of the Health and Social Care Act 2008. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like

Summary of findings

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.

The manager and provider were both based on the premises and sometimes assisted with staffing the service and there were times when people had positive individual attention, but overall the deployment of staff did not provide sufficient staff to meet people's needs at all times.

Although people's care was planned and reviewed periodically, the planning and delivery of care was not sufficient to ensure people's welfare and safety. There were also some risks to safety within the premises that needed attention.

The staff recruitment processes were not robust. Staff knew about the risks of abuse and action they needed to take in reporting any concerns.

Some people did not have full mental capacity to make some decisions and staff were often acting in people's best interests under the Mental Capacity Act (2005) (MCA).

People were supported to eat and drink enough and their health needs were monitored and met by relevant health services when needed.

Staff were described as kind and caring. They spoke respectfully to people and showed patience. People appeared comfortable and relaxed when they received attention from the staff, but there were times when people did not receive sufficient attention to meet their needs.

Staff demonstrated some good practice in maintaining people's dignity, but privacy and dignity were not always maintained and personal information was not kept totally secure.

Staff were providing activities to meet the needs of people living with dementia. Some specific activities were available for people.

The quality of the service was not sufficiently monitored in order to ensure people's care and treatment was always safe, but the registered manager led the staff team with support of the provider and senior staff and encouraged a positive culture among the staff group.

There were breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 corresponding to Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to ensuring people's welfare and safety, risks to safety within the premises, the deployment of staff and staff training. There was also a breach of the Health and Social Care Act 2008 (Registration) Regulations 2009.

You can see what action we told the provider to take at the back of the full version of this 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?

Requires improvement

The service was not consistently safe.

Care was planned, but the planning and delivery of care was not sufficient to ensure all people's welfare and safety. There were some risks to safety within the premises.

People had some positive individual attention, but overall the deployment of staff did not provide sufficient staff to meet people's needs safely at all times.

The recruitment and selection processes were not robust, but staff knew about the risks of abuse and action they needed to take in reporting any concerns.

Is the service effective?

Requires improvement

The service was not consistently effective.

Some staff had received recent training, but others had not.

Consent was obtained whenever possible. Some people did not have full mental capacity to make some decisions and staff were often acting in people's best interests under the Mental Capacity Act (2005) (MCA).

People were supported to eat and drink enough and their health needs were monitored and met by relevant health services when needed.

Is the service caring?

Requires improvement

The service was not consistently caring.

People were cared for by staff who spoke respectfully to people and showed patience. People appeared comfortable and relaxed when they received attention from the staff, but there were times when people did not receive sufficient attention to meet their needs.

Staff demonstrated some good practice in maintaining people's dignity, but privacy and dignity were not always maintained and personal information was not kept totally secure.

Is the service responsive?

Requires improvement

The service was not consistently responsive.

Sufficient staff were not always available to respond to people's needs, but some activities were provided to meet the needs of people living with dementia.

The complaints procedure was not clear for people.

Summary of findings

Is the service well-led?

The service was not consistently well led.

The manager led by example, gave guidance to other staff about how to meet people's needs and encouraged a positive attitude amongst the staff.

However, the manager had not provided information to the CQC when requested or required.

The quality of the service was not sufficiently monitored in order to ensure people's care and treatment was always safe

Requires improvement

Oakapple 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 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 unannounced inspection took place on 19 March 2015 and was carried out by one inspector.

Before our inspection, we requested information from the provider in a Provider Information Return, but we did not receive any information. We reviewed all other information we hold about the service. This would include any notifications we had received about incidents, but none had been submitted since the last inspection. A notification is information about important events which the provider is required to send us by law.

We spoke with two people living at the home, one regular visitor, a visiting health professional, four care staff, the manager and the provider.

We looked at the care plans for three people, the staff recruitment and training records, all current medicine records and other records relating to the management of the home.

We observed care and support in shared areas and we also used the Short Observational Framework for Inspection (SOFI) in one area. SOFI is a specific way of observing care to help us understand the experience of people who cannot fully express their views by talking with us.

We also consulted commissioners of the service who shared their views about the care provided in the home

Requires improvement

Is the service safe?

Our findings

During our previous inspection on 19 February 2014 we found the provider was in breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, as the assessment of risks and the monitoring process used did not ensure that people's welfare and safety was protected. The manager sent us an action plan on behalf of the provider and told us they had discussed with staff how to review risks and report changes to the manager so that action was taken to protect people.

During this inspection, we saw in care plans that staff had been evaluating individual needs and risks and, for two out of three care plans, the last evaluations were within the last month. However, not all information was up to date to ensure staff had access to reliable, written information about how to meet people's individual needs. We saw staff inappropriately assisting a person to transfer from their wheelchair to a lounge chair. The person was unable to weight bear and the care staff were lifting and dragging the person between them. The person was uncomfortable and unsafe on the edge of a chair and the manager arrived during this procedure to assist the staff and ensure the person was made comfortable and safe. The person's needs and risks had recently changed due to ill health, but this was not clarified in the care plan. The staff had not assessed the risks of moving someone who was not able to bear their own weight. The manager said that staff should have used a hoist to move any person that was not able to weight bear. The method used by staff was unsafe for the person and staff. We saw the hoist was safely used on another occasion when staff assisted a different person.

A visiting healthcare professional told us that another person had fallen twice in the home and had sustained injuries that needed medical attention. The health professional had given advice after the first injury, but not all the suggested action had not been taken to prevent further injury. During this inspection further advice was given and a meeting was arranged with the person's family.

These two examples meant the planning and delivery of care was not sufficient to ensure people's welfare and safety. The provider was still in breach of Regulation 9 (1)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 12 (2)(a),(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was information in care plans about other risks to people's health and we saw that attention was given to risks involved in the use of bedrails and reducing the risk of developing pressure ulcers. We saw pressure relieving mattresses were in place where needed.

During our previous inspection on 19 February 2014 we found the provider was in breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, as people were not protected against the risks associated with unsafe premises. We had noted that radiators throughout the building were sharp on the corners and were a risk if anyone fell against them. There were also unpleasant odours in some areas. The action plan we received stated that radiator guards would be installed for all radiators.

During this inspection, we saw radiators in corridors had been covered. However, one cover in the entrance area was not fixed to the wall and staff told us that one person who lived at the service often rattled the cover and we found it could easily fall off the wall. None of the bedroom radiators were covered and in two of the rooms the radiators were very hot. In one room we saw an open electrical fuse box next to a bed. The manager explained that the bed was not used, as this was a double room used by a single person who used the other bed in the room. However it still posed a risk to anyone else who may be in the bedroom.

In addition, we found there was still an unpleasant odour associated with one bedroom carpet. The provider and manager agreed that they still needed to replace it.

The risks to safety within the premises meant there was still a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were not sufficient numbers of staff available to ensure people's needs were met safely. We observed people waiting for staff to attend to their personal care and other needs. There were three staff, during the morning, providing care to the eight people at the home. The same staff were also responsible for cooking and cleaning. There were two staff in the afternoon. The manager had been on duty through the night and the provider had also been called upon to provide assistance during the night. We saw instances where people's needs were not being properly met and their dignity not respected, because of the lack of

Requires improvement

Is the service safe?

available staff. Staff moved people into the lounge in wheelchairs and left them in the middle of the room waiting for assistance to transfer to a lounge chair. One person in the lounge spilt hot tea and there were no staff in the room to assist or to respond when we sought assistance on behalf of the person. Another person was in need of personal care, but no staff were available to assist until we found a member of staff in the kitchen and asked them to attend to the person's needs. A regular visitor told us that there were often no staff in the lounge during the late morning and they had previously seen one person fall to the floor at this time. In the afternoon one person was sitting unhappily in another lounge and told us, "I just want them to help me to my bed. How much longer will they be?" We ensured staff responded and assisted this person.

Staff told us there were times of the day when they had to give priority to attending to individual people's personal care and could not be available for others, but they tried to "keep an eye on everyone".

We discussed the staffing situation with the manager and provider, who said they were often around the home themselves to support staff, particularly at mealtimes and we saw them both assisting people with their meals at lunch time. The manager also informed us immediately following our visit that all staff had been instructed to make sure people in the lounge were never left unattended.

However, the way the provider deployed staff meant there were insufficient staff to meet people's needs at all times and this was in breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The staff recruitment processes were not robust. One of the staff told us they had been through a formal recruitment process and there had been a range of pre-employment checks. However, when we saw records we found that for the most recently appointed person there was just one reference and no criminal records check. There was no information that suggested the person was not of good character, but the home's own policy and national guidance to make sufficient checks on people before they started work with vulnerable people had not always been followed. The manager started to pursue the checks as soon as we identified this.

We saw that medicines were stored securely, though when we were sitting with a person in the lounge we saw that a tablet was stuck to their clothing. This meant staff had not ensured it had been taken as prescribed. We discussed this with the manager who immediately instructed all staff to observe people carefully to ensure medicines were taken.

We looked at the medicine administration record (MAR) sheets and saw that staff had initialled the record for each person's medicines when they were given or recorded if they were refused. There was a photograph of each person to aid identification and full information was given about the medicines and how they were to be given. We saw there were some medicines that were listed in handwriting and not all of them had been checked by a second member of staff to make sure the correct information and instruction was written down as prescribed.

Staff told us they had received training in safeguarding procedures. It was included in the induction training booklet and one new member of staff told us they had received a great deal of training at the local college about the actions they needed to take should there be any concerns about abuse of any kind. From our discussions with another staff member we were assured that they knew about the risks of abuse they gave us examples of how that showed us that they understood what action they needed to take in reporting any concerns.

Requires improvement

Is the service effective?

Our findings

One senior staff member told us they had not received any refresher training for over four years and the training plan confirmed this and other training needed. The manager told us that she had also not done refresher training, but was planning to arrange more training for the more experienced staff in order to further develop their knowledge and skills. One new care staff told us they were employed under the apprenticeship scheme and had care training through the local college. They had also completed training in dementia care and mental health that was arranged by the provider.

Staff told us they could approach the manager or other experienced staff should they need support at any time. They met as a staff group, but did not have regular individual supervision meetings, They could, though, discuss anything informally with the manager or when the manager wanted to talk to them about something. However, this meant that some staff may not have their training needs reviewed on a regular basis and people were at risk of receiving unsuitable or unsafe care, because the provider had not ensured that all staff skills and knowledge were up to date.

The provider was in breach of Regulation 23(1)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 18 (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Staff told us that they obtained people's consent whenever they could before starting any care procedure. There were some signed agreements on people's care plan files to show written consent. Staff knew that they were often acting in people's best interests under the Mental Capacity Act (2005) (MCA), but felt it was an area they needed more training on.

The manager had received recent information on the Mental Capacity Act and the Deprivation of Liberty Safeguards (DoLS). The MCA sets out what must be done to make sure that the human rights of people who may lack mental capacity to make decisions are protected in relation to consent or refusal of care or treatment. DoLS protect the rights of adults using services by ensuring that if there are restrictions on their freedom and liberty these are assessed by professionals who are trained to assess whether the restriction is needed. We saw examples of appropriate assessments and plans which had been completed for people who did not have full mental capacity to make some decisions. These plans provided guidance to staff about how to act in people's best interests. In our discussions with staff, they told us they knew when they needed to assist people with some decisions and they gently encouraged people to receive their personal care. The manager told us there had been not been any need to apply for any DoLS in respect of anyone at the home in the past, as the door was not locked. They kept people safe by having an alarm that sounded whenever the door was opened. Our discussions with the manager demonstrated she had an understanding of DoLS and how to protect people's rights.

A visitor said, "The food doesn't always look very appetising to me, but I've not actually tasted it and they seem to have enough." We saw that people were enjoying their lunchtime meals

We also saw that staff made people drinks and provided them throughout the day.

One of the care staff was responsible for preparing the main meal each day. A care staff member told us that all the staff were aware of individual people's dietary needs. They explained how they supported a person who was diabetic. Another person required all meals to be liquidised and we saw that this was done appropriately. The provider, manager and care staff helped people with their meals. We saw that people were supported to eat and drink enough. We saw records in the care plans that showed people were weighed regularly in line with advice and we saw that written guidance that was being followed by staff for a person who was at risk of choking.

Staff told us that if they had any concerns about someone's health they reported these to the manager or head of care, who discussed the concerns with the person and a GP was called. There were records of regular contacts with visiting health care professionals for advice and treatment. One person had been treated for a pressure ulcer by the visiting community nursing team and this was healing well. Staff described how they ensured people were assisted to change position during the night to avoid such sores. We also saw records of visits from mental health practitioners and a chiropodist. This showed that health needs were monitored and met by relevant health services when needed.

Requires improvement

Is the service caring?

Our findings

The service was not always caring. One person told us, “All the staff are kind, but they are sometimes too busy to come to me.” There were also times when people did not receive attention at all and this was not caring. We observed during the morning that two people were left in their wheelchairs in the middle of the lounge while they waited for assistance to move into lounge chairs. Two others were also in need of attention to meet their individual needs to keep them safe.

We observed staff talking and interacting with people at various times during the day. We saw examples of when they gave very positive individual attention, which was aimed at making people feel special. People appeared comfortable and relaxed when they received attention from the staff. A visitor told us, “They are all very patient and caring in the way they speak to people.”

Staff told us they always offered choices to people and gave opportunities for people to respond before proceeding and we also observed this in practice. We saw that when staff were present, they understood the different ways people communicated their choice or agreement about where they sat or what drink they wanted.

The manager had information about advocacy services if anyone needed an objective person to speak on their behalf, but they told us that no one was using this service at present. However, each person had relatives or had given power of attorney to an alternative person who would assist in making decisions about their care. We saw relevant information about this in people’s care plan folders.

A senior staff person told us they had previously received training in privacy and dignity and had become a ‘Dignity Champion’. This meant they promoted dignity and reminded other staff about good practice in maintaining people’s dignity. Other staff told us they always made sure doors and curtains were closed when they were assisting people with personal care. We saw that staff did assist people with respect. However, privacy and dignity were not always maintained as staff were not available to ensure the dignity of people in the lounge at all times. Also, we saw that people’s care plan information was not kept totally secure as care plans were kept on open shelves in an unlocked room.

Requires improvement

Is the service responsive?

Our findings

There was a lot of information in care plans about people's care needs and how staff should meet them. Staff told us they all had time to read the care plans when they first started work at the home and they soon got to know individual people's needs as it was a small home with currently only eight people living there. Team leaders were responsible for evaluating the plans each month and keeping them up to date. The manager told us that people's family members had been involved with providing information and agreeing the plans of care. She also said that she contacted family members whenever there were concerns or changes in people's needs which meant the plans were changed.

A visiting health professional told us that the manager had not fully responded in the past to advice given about meeting one person's needs. The manager was involving the family member of the person, but had not changed the care plan. Further action was being taken during our visit in response to the current concerns and to ensure the person was safe.

In addition, we witnessed occasions when staff were not responding to people's needs as they were engaged in other tasks. For example, people were not fully supervised in the lounge and had needs related to their specific mobility and personal care. Staff were not always available to respond to these needs in order to keep people safe. This was linked to insufficient staff being available at key times of the day.

There were sections in the care plans that contained information about people's social history, interests and preferences. Staff said this information was helpful in conversations and providing activities. Staff told us that they had been out individually with people sometimes to walk around the gardens or to the local church. They also said they assisted people to do some art and craft work at times. We did not see these activities, but we did see that there were some individual sensory items attached to aprons, cushions and gloves. These were in use with some people during the day, with the aim of providing some stimulating activity, which is responsive to the needs of people living with dementia.

People could choose to spend time wherever they wished in the home, though some were reliant on staff to move from one place to another and their choice was limited to times when staff were available to assist them. One person walked around different areas. Most people were in the main lounge areas during the morning and some had bed rest in their own rooms during the afternoon or spent time in a small lounge.

There was a small box in the reception area of the home for people to leave comments about the service, but the manager told us there were never any comments left. Information about how to make a complaint was given in a folder. However, the procedure was not clear or up to date. Staff did not know the procedure, but said they would report any complaints to the manager. There were no records of any complaints received.

Requires improvement

Is the service well-led?

Our findings

The manager was available on the premises during this inspection. However, she was not appropriately registered as manager. We had discussed this with her during the previous two inspection visits to ensure she was aware that she should have reapplied for her registration. Also, the CQC had sent information by email and requested information about the service prior to this inspection. The manager confirmed the email address was correct and told us she had not looked at her email for quite some time. Immediately following this inspection, the manager provided evidence that she had commenced the registration process.

We had not received any notifications during the previous year, but there was one incident that we became aware of that should have been notified to us. This concerned an injury and, without the information at the time, we were not able to check that appropriate immediate action had been taken or that follow up action was taken.to help to prevent similar injuries in the future.

However, staff leadership was provided. Staff told us that the provider and the manager were on the premises for the majority of the time and often worked with them in caring for the people that lived there. We saw this in practice and it was clear that the manager led by example and gave guidance to other staff about how to meet people's needs. Another experienced care worker was known as the Head of Care and acted as a deputy for the manager in her absence. Other staff said that they could easily approach either of these for assistance at any time and they were also on call if needed outside of their normal working hours. In addition there was a team leader as part of the care staff team on duty. This meant that newer care staff members always had someone they could consult if they needed immediate advice.

Two staff told us they thoroughly enjoyed their work and they found the staff group, manager and provider were all positive in their attitude to caring for the people in the home. A visitor told us, "They are all involved in the care and seem to enjoy looking after the people here."

We saw that there were some audits and checks on the quality of the service. The manager had taken guidance from an environmental health officer and was making regular checks on water temperatures and taking action to ensure the system was appropriately kept free of Legionella. However, other checks on the premises had not been completed and action had not been taken to ensure all areas were safe. This meant the manager and provider were not aware of the concerns we found until we told them. For example, they were not aware that action was needed to make sure there were no risks from radiators. They were also not aware that a criminal records check had not been completed for one person or that some staff had not received all the required training.

There had not been any formal meeting with the people that lived there and the family members in order to discuss the quality of the service. There were no surveys carried out about the service provided. We saw information about the service was available for visitors in the entrance hall, but this was not up to date. However, the manager responded to all the concerns we identified during our visit by forming an immediate action plan that she sent to us following this inspection visit. The content of this showed that the manager was determined to make improvements.

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.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment How the regulation was not being met: The planning and delivery of care was not sufficient to ensure people's welfare and safety. Regulation 12 (2)(a),(b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment How the regulation was not being met: People who use services and others were not protected against the risks associated with unsafe or unsuitable premises because of inadequate maintenance. Regulation 15 (1) (a), (e)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing How the regulation was not being met: The way the provider deployed staff did not provide sufficient staff to meet people's needs at all times. Regulation 18 (1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing How the regulation was not being met: Training was not provided as is necessary to enable all staff to carry out their duties in meeting people's needs. Regulation 18 (2) (a).