Rushcliffe Care Limited

Oakford Manor Nursing Home

Inspection report

Newshaw Lane
Hadfield
Glossop
Derbyshire
SK13 2AJ

Tel: 01457861117
Website: www.rushcliffecare.co.uk

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Ratings

Overall rating for this service	Good

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?	Good

Summary of findings

Overall summary

Oakford Manor Nursing Home is a 'care home with nursing'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Oakford Manor Nursing Home accommodates up to 50 people in one adapted building. At the time of our inspection 30 people lived at Oakford Manor Nursing Home.

At our last comprehensive inspection in July 2016 we rated the service as 'Good.'

Risks associated with medicines were mostly well managed; however some medicines were not stored securely in people's rooms. Staffing was mostly sufficient; however there was an occasion when staff were not free to respond and check a person was safe. Systems and processes were in place to safeguard people from abuse; these covered staff recruitment practices and staff training and knowledge on safeguarding procedures. Systems also ensured accidents and incidents were recorded and analysed and steps to improve and learn were identified. Actions were taken to reduce known risks including those from infection. Actions were taken to reduce falls however, the service had not always identified when control measures to reduce the risks associated with falls were not effective.

We have made recommendations regarding the deployment of staff and the management of risk.

People's needs for a balanced diet, including any specific dietary needs, were identified and met. Where people required healthcare from other professionals this was arranged and helped to ensure good on-going healthcare support for people. The premises had been changed to ensure they were fully accessible to people. People are supported to have maximum choice and control of their lives and staff support them in the least restrictive way possible; the policies and systems in the service support this practice. Staff were supported and trained to have the skills and knowledge in areas relevant to people's needs. Assessments of people's needs were in place. They included assessments of any health related needs as well as any diverse needs including those in relation to a person's religion or disability.

The staff team were caring, kind and friendly. Staff had developed positive relationships with people and knew them well. Staff were mindful of promoting people's independence and respecting their privacy and dignity. People were supported to be actively involved in decisions about their care.

Systems were in place to ensure complaints could be made and were investigated. People had opportunities to give feedback and raise any issues and have them responded to. People's care and support reflected their preferences and choices and identified what was important to them. People and when appropriate, their relatives, were involved in making decisions about their care. Staff understood how people communicated and involved people in their care and gave them choices.

A registered manager was in place and they understood their responsibilities for the quality and safety of the

service. Systems and processes were in place to assess, monitor and improve the quality and safety of services. The service was focussed on achieving good quality outcomes for people and worked in partnership with other health and social care professionals to ensure people received appropriate care. People, relatives and staff had opportunities to engage and be involved in the development of the service.

Further information is in the detailed findings below

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 remains not consistently safe.

Methods used to help prevent falls had not always been identified when they were ineffective. Staffing levels meant staff were mostly, but not always able to respond to check people were safe. Not all medicines were stored securely. We have made recommendations about staff deployment and the management of risk.

People felt safe and systems were in place to help protect people from abuse and avoidable harm. Infection prevention and control practices were in place and followed.

Is the service effective?

Good

The service remains 'Good'

Is the service caring?

Good

The service remains 'Good'

Is the service responsive?

Good

The service remains 'Good'

Is the service well-led?

Good

The service remains 'Good'

Oakford Manor Nursing 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 responsive inspection took place on 12 and 20 March 2018. The first day was unannounced and was completed by one inspector, a specialist professional advisor, whose area of specialism was nursing and falls prevention and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. Their area of expertise was in the care of older people. The second day of the inspection was carried out by one inspector.

Before the inspection we looked at all of the key information we held about the service, this included whether any statutory notifications had been submitted. Notifications are changes, events or incidents that providers must tell us about.

This inspection was prompted in part by a pattern of notifications concerning serious injury. Information of concern had also been reported to the Commission prior to our inspection regarding staffing levels. Relevant incidents had been brought to the attention of the local authority safeguarding team. The information we held about the service before our inspection indicated potential concerns about the management of risk in the service. Where an incident could be subject to criminal investigation, the circumstances of that specific incident were not investigated as part of this inspection. We did however look at the associated risks. These included management of risks associated with people's care needs, including falls and staffing levels.

As this was a responsive inspection we did not ask the provider to complete a Provider Information Return (PIR) prior to our inspection. This is information we require providers to send us at least once annually to

give some key information about the service, what the service does well and improvements they plan to make. We took the information from the PIR completed by the provider in 2017 into account when we inspected the service and made the judgements in this report.

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.

During the inspection we spoke with four members of care staff, the medicines administrator, the activities coordinator, the registered manager, compliance officer and assistant director. We spoke with nine people who used the service and with four family members.

We spoke with the local authority and health commissioning teams and Healthwatch Derbyshire, who are an independent organisation that represents people using health and social care services. Commissioners are people who work to find appropriate care and support services which are paid for by the local authority or by a health clinical commissioning group.

We looked at the relevant parts of six people's care records. We also looked at records that related to how the service was managed including staffing, training and quality assurance.

Requires Improvement

Is the service safe?

Our findings

At our last inspection, the rating for 'safe' was 'requires improvement'. This was because people were not consistently protected from the risk of infection. At this inspection we found improvements to infection prevention and control had been made.

People told us staff helped them to reduce risks from falls. One person told us, "I had a few falls when I was at home on my own but not since I've been here; [staff] are careful not to let me fall." Another person told us, "I don't need help to walk, I can manage on my own; I just need a bit of help when I get dressed so that I don't lose my balance and [staff] are very good about helping me." A relative commented, "I come every day and I see what is going on. The staff are very good and rush to people if they see them struggling to get up." Another relative told us, "I look at the logbook and I can see that [staff] look in on [name] frequently during the night. That's reassuring because depending on how [name] is feeling, they can wander; I think it's very good here."

The registered manager monitored and analysed falls for any patterns that would help them identify how to further reduce risks to people. They had identified one person who was at high risk of falls and had liaised with other health care professionals for a review of medicines to help prevent further falls; this had been effective. They had also made referrals to the falls prevention team. An alert mat had been assessed as required to help prevent falls by alerting staff when the person began to mobilise. However, we observed this was ineffective and staff we spoke to were aware it was ineffective but could not tell us what they had done about it. We made the registered manager aware of our observations. On the second day of our inspection a different method to help prevent falls for this person was in place. We observed that this appeared to be more effective. Whilst we were concerned the service had not always identified when control measures to reduce the risks associated with falls were not effective, other actions had been taken to ensure risks from falls were reduced.

We recommend that the service seek advice and guidance from a reputable source, about the management of risk.

Other risks to people associated with their healthcare conditions and general risks in the environment were identified. For example, we saw the front door was secure and staff understood any risks around people's nutritional needs, skin care and diabetes. However, we found one person's care plans contained conflicting information on what support the person required from staff with their meals. On day two, the registered manager had reviewed and updated this person's care plans to ensure they were consistent.

The registered manager was in the process of reorganising people's care plans to ensure relevant information about people's needs and preferences was more prominent. We found records were mostly up to date, however on the first day of our inspection, not all records were stored safely. This was because care plans in both the downstairs and upstairs cupboards were not locked. On the second day of our inspection this had been rectified and records were stored securely.

Prior to our visit we received concerns about staffing levels and we discussed these with the local authority, clinical commissioning group and the provider. On our inspection visit, people we spoke with did not report any concerns with staffing levels. One person told us, "I am never kept waiting; [staff] come straight away if I press my buzzer, sometimes they're a bit too quick." Another person told us, "Mostly there's enough staff around." A third person told us, "During the day [staff] are always around [in the lounge], so if you want anything you can just tell them. At night I don't often need any help but they come quickly if I do." However, most relatives told us they felt the service was short staffed. One told us, "I think they are short staffed; the staff are really good but they could definitely do with an extra pair of hands." Another relative told us, "They are definitely short staffed; [staff] have too much to do which means they can't do everything." Whilst a third relative told us they thought staffing had improved, they said, "At one time there seemed to be a lot of agency staff but that's settled down now and I see the same people every time I visit; it's a lot better."

Staff we spoke to also had mixed views on whether staffing levels were sufficient to meet people's needs. Some staff told us there were enough staff. However, one staff member told us they would work through their breaks to ensure people's care needs were met; another expressed concerns over how rushed they felt in order to meet people's needs. During our inspection we observed most people received care in a timely manner and staff checked on communal areas regularly. However, we observed one person, who was a falls risk and whose alarm mat had triggered, was not attended to by staff in a timely manner. We spoke with staff about whether they could always attend on time when the person's alert mat sounded; one told us, "I'd like to say someone should be there all the time but there is only two of us here so we can't." They told us if they were both providing care to other people they were not always free to respond. The registered manager told us they were in the process of requesting a review with commissioners for a review of the person's care needs.

We fed back the views that had been shared with us and discussed how staffing levels were planned with both the registered manager and assistant director. They both told us staffing levels were calculated depending on people's levels of need; in addition they said they remained receptive to feedback from people, staff and families to continue to understand any staffing pressures and make adjustments when needed. The provider had previously responded to concerns over staffing levels by talking with staff and identifying specific pressures; as a result they had increased staffing levels. Staffing rotas showed the amount of staff calculated as needed had been deployed. Sufficient numbers of staff were deployed based on people's current dependency levels, however we had observed there was still one occasion when staff had not always been free to respond and check a person was safe.

We recommend that the service finds out more about deployment of staff, based on current best practice, in relation to the specialist needs of people using the service.

People received their medicines as prescribed, and when people required medicines for pain relief we saw these were offered. One person told us, "The nurse is very good. She brings my tablets and a drink of water and waits until I've taken them." A relative told us, "It's not always easy to tell if [name] has any pain but [staff] seem to be able to gauge it and give some pain relief." We observed one staff member sat with a person and chatted to them; during the conversation they asked how they felt and the person mentioned they were experiencing some pain. The staff member offered them some pain relief which the person accepted. We found suitable arrangements were mostly in place to safely manage people's medicines in line with national guidelines. Most medicines were stored safely, however we found some people's creams and ointments were left out in their bedrooms and their bedroom doors were open. This meant there was a potential risk to people living with dementia who may be able to access other people's medicines. We made the registered manager aware of our concerns.

Systems were in place to help people stay safe. People and families we spoke with told us they felt safe living at Oakford Manor Nursing Home. One person told us, "I feel very safe as the staff look after me really well." Another person told us, "All I want is to be safe, to be looked after and to feel as though [the staff] care about me. I get all of that here. I wouldn't want to go back home because I know I'm safe here." A relative added, "[Name] is extremely safe here and the staff are brilliant. [Name] was in another home before they came here and they were fading before my eyes. Since they've been here they've put some weight on and [name] tells me they feel really secure." Staff understood how to identify signs of abuse and preventable harm and knew how to report these; staffs' knowledge in safeguarding adults had been supported by training in this area. Staff told us and records confirmed, checks were made on their suitability to work with people using the service as part of their recruitment. These checks included a disclosure and barring service check, checks on previous employment history and obtaining references. There were systems, processes and practices to safeguard people from situations in which they may experience abuse.

Suitable measures were in place to prevent and control infection. Staff had received training and understood how to prevent and control infection. Staff told us and our observations showed they had adequate supplies of gloves and aprons to help prevent infection.

We found a system was in place to ensure lessons were learned and improvements made when incidents or accidents occurred. Records showed arrangements were in place to analyse incidents so that they could establish how and why they had occurred. Reviews of incidents considered how to reduce the likelihood of the same thing happening.

Good

Is the service effective?

Our findings

People who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the MCA. The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

Our observations showed staff checked people's consent for their care; for example staff asked people whether they would like anything to help protect their clothing over lunchtime. One person told us, "[Staff] are always asking me; everything they do, they say, 'is it ok?' I'd soon tell them if I didn't like anything." Staff we spoke with understood the importance of only providing care to people with their consent. One staff member told us, "We always respect people's wishes if they say, 'No'; we will retry later and if still 'No', we make the nurse aware." Records showed the service was working within the principles of the MCA. For example, policies that covered the MCA and making decisions in a person's best interests had been followed. Where appropriate, applications for DoLS authorisations had been made with a system in place to monitor and meet any associated conditions. People's consent to their care and treatment was sought by staff in line with the MCA.

Assessment of people's diverse needs, including in relation to protected characteristics under the Equality Act 2010 were considered in people's care plans with them. Records showed how people's disabilities and health conditions had been assessed and what care was required to meet those associated needs. For example, we saw needs associated with a person's diabetes had been assessed. In addition, other protected characteristics, such as a religious faith had been identified and steps taken to meet those associated needs. Assessment processes were in line with current legislation and standards and helped to achieve effective outcomes for people, including helping to prevent and reduce the impact of discrimination.

People and their relatives were positive about the quality and choice of food and drinks. One person told us, "I like the food." Another person told us, "There are a few different choices at lunchtime; [staff] ask what you want." We saw a person changed their mind over what they wanted to eat when their first choice had already been provided. Staff provided the person's second choice quickly and without any fuss. We observed drinks were regularly provided to people. Relatives told us they were offered the opportunity to join their family members for lunch if they visited at that time; this helped to encourage enjoyable mealtimes. Staff were knowledgeable about people's different dietary requirements and records showed where people's food and fluid intake required monitoring this had been completed. People were supported to maintain a balanced diet.

People were supported to live healthier lives by receiving on-going healthcare support. For example, records showed a digital health system was used so changes in people's needs could be reviewed quickly and efficiently. This identified where further follow up healthcare services were required, for example we saw where the person went on to see their own GP or required admission to hospital. Relatives told us their family members had good access to their GP if needed.

Staff told us they worked well together as a team to provide effective support. Handover records showed

staff regularly discussed people's care needs, any changes and any subsequent actions in response. These actions helped people receive effective care and treatment.

Staff told us and records confirmed they received training to have the skills and knowledge to meet people's needs effectively. Training covered areas such as, health and safety, infection prevention and control and nutrition. Staff told us they worked alongside more experienced staff when they first started to help them understand people's needs. One staff member told us, "I teamed up with a senior for a week until I felt confident; I didn't feel rushed into [working on my own]." Staff told us they received supervision and feedback on their practice and they could talk to the management team at any time if they required support. One staff member told us, "I get feedback on how to improve; it's helpful to take on board and it's constructive."

People's individual needs were met through the adaption of their premises when needed. The building was accessible and people could access a lift between the ground floor and first floor. Corridors had use of grab rails and some signage was in place to help people orientate around the premises. People's rooms were personalised and reflected their choices and tastes.

Good

Is the service caring?

Our findings

People and their relatives told us staff were kind, caring and friendly. One person told us, "[Staff] are very kind," another told us, "It's their job to look after us but they are all smashing." A relative told us, "The staff are fantastic; I come [several] times a week and I've seen nothing but kindness towards people here." Staff shared the view the culture at the service was a caring one. One staff member told us, "I feel confident staff are kind." We observed staff interacted positively with people, sharing conversations about their interests and having jovial conversations.

People told us staff respected their privacy and dignity and they were happy with any support for their personal hygiene. For example one person told us, "I like to have a shower most mornings when I get up and it doesn't matter what time it is, [staff] will come and help me." Minutes of a meeting with people showed they had discussed being cared for with dignity and had been helped to write some words about what dignity meant to them. We saw these had been used to decorate a 'dignity tree' in the reception area. We observed people were supported to look well-presented and people who chose to have manicured nails did so. People were offered additional protective garments during their lunch to help keep their clothes clean. We saw staff knocked on people's bedroom doors before entering and kept them closed if supporting people with personal care.

Staff spoke with us about how they provided care to respect people's dignity and promote their independence. One staff member told us, "We promote people's independence, for example [name] is quite mobile and able to dress themselves; [another person] has had a stroke and can use one side more than the other; we always make sure they can hold their cup and put it to their mouth." People received care that supported their privacy and dignity and promoted their independence.

Not everyone we spoke with knew they had a care plan; however they did tell us they were involved in decisions about their care. One person told us, "I don't know about a care plan but I tell them exactly what I want or don't want." Other people told us, "I go to bed when I'm ready," and, "They ask me everything." Relatives told us they were involved in their family member's care plans and kept informed about their care and treatment. One relative told us, I have been involved from the word go in the care plan."

Whilst care plans contained people's own views and preferences this was not always prominent and the registered manager was in the process of reorganising people's care plans to ensure this was more clear. Staff had told us whilst they knew about people's care plans they had very little input into them. The registered manager told us the reorganised care plans would allow staff to contribute their views more on people's care plans.

Good

Is the service responsive?

Our findings

People told us they were happy with the care they received and could spend their time as they wished. One person told us, "I get everything I need." Another person told us, "I please myself where I want to be. Mostly I like to watch TV in the morning but then after lunch I might go for a lie down; it's up to me." A relative told us, "I'm taking [name] to my house today for lunch; [their friend] is coming as well as they enjoy the change of scenery and meeting old friends." We spoke with the staff member who coordinated activities, they told us they tried to tailor activities to suit each individual. They said, "We have reminiscences as well and I bring in items they might remember like [washing products people would recognise] or lumps of coal; things to get people talking. Some people don't like to join in and I spend one to one time with them and just talk about their families and things that have happened in their lives."

On our inspection visit, people were invited to take part in a church service that was taking part in one of the communal lounges. We also saw people's art work was on display in their rooms and in main communal areas. Care staff we spoke with told us although at times they felt very busy they would take time to be with people. One staff member told us, "We make the time to sit and chat." Our observations showed staff did spend time with people talking about things of interest with them. People enjoyed how they spent their time and took part in activities they enjoyed.

People's care plans were used alongside daily handover sheets and contained important information on people's needs, such as allergies, any dietary needs or any exercises people needed support with. Relatives told us staff would update them over any changes to people's needs. One relative told us, "Communication is really good in that respect; staff will always get in touch if [name] is not well or they are worried about them at all; they do involve me all the time." Care was centred on people's individual needs.

People's communication needs were assessed. Visual menus were available to help prompt people as to the food and drink choices available. The activities coordinator as knowledgeable about which people used audio books and told us they assisted people to choose these when the mobile library visited. Staff were knowledgeable about people's communication needs. One staff member told us how they were speaking to one person who had limited communication skills and how their communication ability had unexpectedly improved. They told us, "It was just the best thing that has happened in my job." They told us and records confirmed how referrals were made to speech and language therapists to assist people's communication needs. The Accessible Information Standard was being met.

The service involved people in discussions about their care and their communication. Relatives told us they were invited to meetings on a regular basis where they had the opportunity to contribute their views. Minutes of meetings with people as well as with their relatives, showed meetings were held and discussed areas of interest to people. For example, one meeting with people discussed the mother's day lunch menu where people's families were invited to join them. We saw people and their families had opportunities to be involved about the service.

No one was receiving end of life care on the day of our inspection visit, however the registered manager told

us how the service and staff provided this care when it was needed. The registered manager spoke about working towards having a specific care pathway in place for end of life care; as part of this, nurses had completed end of life care training and the registered manager attended specific meetings with GP's. Care was available for people at end of life when this was needed.

The provider had a formal complaints policy in place, to manage any complaints. Complaints received had been recorded, investigated and complainants had been responded to within the timescales set by the provider's complaints policy. Relatives told us they were happy any issues were resolved and felt confident to raise these. One relative told us, "I was concerned about [name's] teeth. Sometimes when I came in it didn't look as though they'd been cleaned and they can't do it themselves. I spoke to the manager and she's put a notice in their log book saying their teeth must be brushed twice a day; it's fine now." Processes were in place so complaints and feedback would be handled in a transparent manner and used to inform improvements to the service.

Good

Is the service well-led?

Our findings

The service is required to have 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. The registered manager understood when notifications were required and had submitted these as required. Notifications are changes, events or incidents that providers must tell us about. We also saw the CQC's rating for the service was on display as required.

People told us they knew the manager and told us they found them approachable. One relative told us, "There have been a lot of changes but everything seems to be settling down now. A lot of the old staff have gone but the manager has brought her own people in. I wouldn't want you to think I'm being negative; she is very good. If she's in her office, unless she's having a meeting the door is always open, and she is always around the home seeing what is going on and checking things." Staff also spoke highly of the registered manager. One staff member said, "The quality [of care] has really gone up since she's been here."

The service's aims were centred on the needs of people using the service, for example the provider's statement of purpose stated the service would provide personalised care, delivered sensitively and flexibly and in ways which would promote people's privacy, dignity and independence. Staff were trained in areas consistent with the service's aims, for example in positive behaviour support and dignity. Relatives consistently told us they were confident in the service's ability to meet their family members' needs. One relative told us, "I think it's really good here. I looked at loads of places before we settled on this one; it had to be right for [name]." Records confirmed where other health and social care professionals had been involved in their care and treatment. The registered manager was working towards a number of initiatives, in partnership with other organisations, to further support good practice. For example, in end of life care and to develop students' training in health and social care practice. The service was focussed on achieving good outcomes for people by the involvement of other appropriate professionals and promotion of a culture that centred on people's needs.

Systems and processes were effective at assessing and monitoring the quality and safety of services. Audits checked on such areas as medicines and health and safety; other management processes monitored bedrails and air mattresses for safety and correct use, and areas such as the kitchen and laundry were checked to ensure good practice was followed. Accidents and incidents were recorded and monitored and any lessons learnt to reduce further occurrence were identified. Analysis of accidents, incident and audits was also checked by other senior managers, including the Provider's compliance officer; this provided an additional level of scrutiny and further opportunity to identify learning. These overall governance arrangements helped to identify any trends, learn from when things went wrong, manage risk and provide assurances on the quality and safety of services for people.

The results from a survey asking people and their families about their views on the quality and safety of services was on display. This showed people had been asked for their views on a range of issues including

care, food, laundry, activities and staff. Staff contributed their views on the service through team meetings and supervision. Records of team meetings showed good practice was discussed and shared, for example around the role of individual members of staff. In addition, staff had been able to feedback on recent staffing level changes and express some concerns over the impact of the changes which were feedback to the provider's senior management team. In addition, a staff representative met with a senior member of the provider's management team with the aim of being able to directly raise ideas and make comments on the service. Staff we spoke with were enthusiastic and positive about their role. One staff member said, "It's one of the nicest places I've worked; I can't praise them enough, the staff are lovely, so caring to all the clients, they can't do enough for them." Systems were in place to actively engage and involve people, relatives and staff in the service.