Portland Care Services Limited

Oakfield Nursing Home

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

Oakfield nursing home provides residential and nursing care for up to 37 people. Situated on the A6 between Garstang and Lancaster, the home has easy access to the motorway network. The home has a large car park and accessible gardens.

There were systems in place to ensure people's needs were assessed, and their care plan for. Improvements in the way in which the care records are set out would make the information more accessible. The addition of one page profiles relating to each individual living at the home would allow staff to quickly see what people's needs were, the risks related to their care and what their interests were. Activities linked to people's assessed needs, abilities and interests were available, however, some enquiries needed to be made to ensure that everyone living at the home are provided with appropriate opportunities to engage in meaningful daytime activities linked to their assessed needs and interests.

People were able to express their choice in relation to meals and how they spent their time. People knew how to access the complaints process, and know who to talk to if they wanted to raise a concern. People who lived and worked at the home were fully aware of the lines of accountability at the home. Staff spoken with felt well supported by the management team. The systems operated within the home relating to how information was processed and how systems were audited was satisfactory. The systems assisted staff to identify areas of service delivery that required improvement, mitigate risks. People were treated in a kind, caring and respectful way.

There were systems in place to ensure people were involved in their own care planning and support. The training records showed that staff had received awareness training on the subject of end of life care. If people were found to be in need of end of life care, there were systems in place to support this. Staff had access to on-going training and supervision to meet the individual needs of the people they supported. We found that measures were in place to ensure staff received update training and we saw documentary evidence to support this. We saw written evidence that staff supervision was now taking place more regularly and we were satisfied that appropriate measures were in place to address the issues. We have made a recommendation relating to training and supervision to ensure that the registered manager continues to support the staff effectively.

The service had policies in place in relation to the Mental Capacity Act 2005 (MCA) and depriving people's liberty, and these were put into practice. The menu offered people a choice of meals and their nutritional requirements were met. The building was found to be in a good state of repair, and the environment was found to be fit for purpose. The service had procedures in place for dealing with allegations of abuse. Staff were able to describe to us what constituted abuse and the action they would take to escalate concerns.

Employees were asked to undertake checks prior to employment to ensure that they were not a risk to vulnerable people; the records relating to these checks were complete. Risks associated with medicines management, infection control and cleanliness, and environment factors were assessed. Satisfactory

control measures were in place.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

The service had procedures in place for dealing with allegations of abuse.

Staff were able to describe to us what constituted abuse and the action they would take to escalate concerns.

Employees were asked to undertake checks prior to employment to ensure that they were not a risk to vulnerable people; the records relating to these checks were complete.

Risks associated with medicines management, infection control and cleanliness, and environment factors were assessed. Satisfactory measures were in place.

Is the service effective?

Good

The service was effective.

Staff had access to on-going training and supervision to meet the individual needs of the people they supported, and improvements had been made in this area to ensure that all staff received regular support to ensure they could perform their role effectively

The service had policies in place in relation to the Mental Capacity Act 2005 (MCA) and depriving people's liberty, and these were put into practice.

The menu offered people a choice of meals and their nutritional requirements were met.

The building was found to be in a good state of repair, and the environment was found to be fit for purpose.

Is the service caring?

Good

The service was caring.

People were treated in a kind, caring and respectful way.

There were systems in place to ensure people were involved in their own care planning and support

The training records showed that staff had received awareness training on the subject of end of life care.

If people were found to be in need of end of life care, there were systems in place to support this.

Is the service responsive?

Requires Improvement

The service was not always responsive.

There were systems in place to ensure people's needs were assessed, and their care plan for. Improvements in the way in which the care records are set out would make the information more accessible. The addition of one page profiles relating to each individual living at the home would allow staff to quickly see what people's needs were, the risks related to their care and what their interests were.

Activities linked to people's assessed needs, abilities and interests were available, however, some enquiries needed to be made to ensure that everyone living at the home are provided with appropriate opportunities to engage in meaningful daytime activities linked to their assessed needs and interests.

People were able to express their choice in relation to meals and how they spent their time.

People knew how to access the complaints process, and know who to talk to if they wanted to raise a concern.

Is the service well-led?

Good

The service was well-led.

People who lived and worked at the home were fully aware of the lines of accountability at the home.

Staff spoken with felt well supported by the management team.

The systems operated within the home relating to how information was processed and how systems were audited was satisfactory. The systems assisted staff to identify areas of service delivery that required improvement, mitigate risks.

Oakfield 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. The lead adult social care inspector for the service undertook an unannounced inspection at the service on 08 February 2016. A specialist professional advisor with a background in older people's care also took part in the inspection.

This service was last inspected on 14 December 2013, and was found to be compliant in relation to the regulations it was inspected against. The provider sent us a provider information return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

We spoke with a range of people about the service; this included two relatives, nine people who lived at the home, and eight members of staff. We spent time looking at records, which included six people's care records, four staff files, training records and records relating to the management of the home which included audits for the service. Prior to the inspection we reviewed information sent to us from the home such as notifications and safeguarding referrals.

Good

Is the service safe?

Our findings

People's feedback about the safety of the service was consistently good. We asked one person using the service how they felt living at the home. They told us, "I feel safe." A relative told us they thought their family member was safe at the home. They said, "[Person's name] is safe because the staff understand him and know that he likes his routine."

We found that satisfactory procedures for responding to suspicion or evidence of abuse or neglect (including whistle blowing) were found to be in place. The nurse on duty explained that all allegations and incidents of abuse were followed up promptly and any action taken to deal with the issues would be recorded. We saw documentary evidence of incidents were people had raised safeguarding issues, and these had been dealt with promptly and in line with the home's policies. Discussions with staff showed that they had a good awareness and understanding of potential abuse which helped to make sure that they could recognise cases of abuse.

The policies and procedures relating to how staff would respond to physical and/or verbal aggression by service users were publicised and understood by the staff. Staff confirmed that physical intervention or restraint was not used. Instead, the staff employed distraction techniques when people became confused or aggressive. These were written into people's care plans. When incidents of physical and/or verbal aggression by service users took place, these were recorded, and staff were encouraged to discuss the circumstances of the incidents in order to understand why the incident took place. Discussions also took place to see if there were any lessons to be learnt from how the incident was dealt with.

The home's policies and practices regarding service users' money and financial affairs ensured that service users had access to their personal financial records (where appropriate), and safe storage of money and valuables. The registered manager ensured that service users controlled their own money except where they stated that they do not wish to or they lacked capacity. Information held within people's care records showed that safeguards were in place to protect the interests of people who lacked capacity.

The registered manager had policies and procedures in place to respond to whistle-blowers and concerns raised by service users and/or their families. Staff we spoke with told us that the registered manager and service manager had created an open and transparent working environment where workers felt able to speak up if they witnessed poor practice or wrong doing. The nurse in charge explained that they had a commitment to listen to the concerns of workers, and by having clear policies and procedures for dealing with whistleblowing; the organisation believed it welcomed information being brought to the attention of management.

Information held within people's care records showed that there were policies and procedures for managing risk in place, and it was clear that staff understood and followed them to protect people. We looked at the care files of three people and we found that risk assessments were proportionate and centred around the needs of the person. Staff spoken with told us that they enabled service users to take responsible risks, ensuring they had good information on which to base decisions, within the context of the service user's

individual plan and of the home's risk assessment and risk management strategies. We found records to show that risks were assessed prior to admission in discussion with the service user and relevant professionals. Action was taken to put right identified risks and hazards, and service users were given information and advice about their personal situation, to avoid limiting the service user's preferred activity or choice.

Information held within the service records showed that the registered manager ensured safe working practices were in place for issues such as moving and handling, fire safety, first aid and food hygiene, correct storage and preparation of food. Staff were provided with training and information to ensure they fully understood the risks associated with these practices. Information contained with the home's management records showed that regular monitoring took place. We saw service records to show that the registered manager ensured the health and safety checks took place. Up to date safety records were seen that related to the safe storage and disposal of hazardous substances and the regular servicing of boilers. These were found to be satisfactory.

Staff explained that they were provided with training and information on health and safety issues and they said this helped them to ensure they fully understood the risks associated with the operation of the service. Information contained with the home's management records showed that regular monitoring of risks took place. We saw safety records relating the maintenance of electrical systems and electrical equipment had been undertaken apart from those identified earlier in this report. Water temperatures were periodically checked, and the risks from hot water/surfaces were identified and in most cases, action taken to minimise these risks were taken. The risks associated with falls from windows were dealt through the provision and maintenance of window restrictors.

We found that the home had a recorded staff rota showing which staff were on duty at any time during the day and night and in which role they fulfilled. The nurse in charge said that the ratios of staff to service users was determined according to the assessed needs of the service users. She added that that this was not determined using a recognised tool, but purely on the dependency levels of the service user group. We found that the numbers of waking night staff on duty reflected the numbers and needs of service users and the layout of the home. We found that domestic staff and catering staff were employed in sufficient number.

Information held within a selection of the personnel records showed that the registered person operated a satisfactory recruitment procedure. Two written references were obtained before appointing a member of staff, and any gaps in employment records were explored. The registered manager explained that new staff were only confirmed in post following completion of satisfactory pre-employment checks such as those provided by the Disclosure and Barring Service (DBS), and/or the Nursing and Midwifery Council. This was supported with information contained within the personnel records.

We found documentary evidence to show that there was a policy and procedure in place for the receipt, recording, storage, handling, administration and disposal of medicines. The nurse in charge explained that people living in the home were able to take responsibility for their own medication if they wished, within a risk management framework. The nurse explained that following an assessment, people were able to self-administer medication and would be given a lockable space in which to store their medication. However, where people were assessed as lacking capacity to manage their own medicines, or did not want to, then there were systems in place for the staff to do this.

Records were kept of all medicines received, administered and when they left the home or were disposed of, to ensure that there was no mishandling. We looked at the medicines records of three people and found that appropriate records were maintained for the current medication of each service user. However, Staff

spoken with said that they monitored the condition of the people who were prescribed medicines, and call in the GP if concerned about any change to their condition that may be a result of medication. Controlled Drugs administered by staff were found to be stored appropriately.

We found policies and procedures in place for control of infection, which included the safe handling and disposal of clinical waste; dealing with spillages; provision of protective clothing and hand washing. Our observations found that the premises were clean and hygienic. We found laundry facilities were sited so that soiled articles, clothing and infected linen were not carried through areas where food was stored, prepared, cooked or eaten. The washing machines had a specified programme that met appropriate disinfection standards. The home had appropriate sluicing facility that could be effectively used to dispose of soiled material on people's clothing.

Good

Is the service effective?

Our findings

Feedback from people living at the home was positive. A relative of a person using the service told us, "The staff are excellent with [our family member]. They know exactly how to support him."

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. The records showed that following an assessment of the person's mental capacity, which included the involvement of the person, best interest meetings had taken place with relevant professionals and family members to determine how best to support the person. Any potential restrictions place on a person's choice or freedom, were based on a clear assessment of their needs and the risks associated with them. These restrictions formed part of the person's individual care plan.

Staff at the home ensured that service users received a varied and appealing diet, which was suited to individual assessments and requirements. People were offered a choice as to where they would like to take their meals; most meals were offered to people in the dining room, however, people could choose to eat in the lounge or their bedroom. We noted that hot and cold drinks and snacks were available to people throughout the day. Meals, including pureed meals, were presented in a manner that was attractive and appealing. Special therapeutic diets were provided when advised by health care professionals such as dieticians. Mealtimes were observed to be unhurried with service users being given sufficient time to eat. Staff were seen to be ready to offer assistance in eating where necessary, and this was done discreetly, sensitively and individually.

The nurse in charge explained that people were supported and facilitated to take control of and manage their own healthcare as much as possible. However, the staff team took on responsibility for prompting people's healthcare, monitoring their condition and arranging appointments for treatments or reviews. A review of the care records of four people showed that people were supported to either attend GP and healthcare appointments, and if they were assessed as unable to leave the building due to illness or disability, then staff arranged home visits.

The location and layout of the home was suitable for its stated purpose. The service had a programme of routine maintenance and renewal for the fabric and decoration of the premises. Satisfactory toilet, washing and bathing facilities were provided to meet the needs of service users; they were accessible, clearly marked, and close to the lounge and dining areas. People were seen to have access to all parts of the home, apart from spaces that were not their own private rooms. We observed that grab rails and other mobility aids were provided in corridors, bathrooms, toilets, communal rooms and where necessary, in people's

bedrooms. Hoists, assisted toilets and showers were available for people to use.

Our observations showed that the staff working on the day of our visit were able to communicate effectively with people living at the home. The records showed that new staff received induction training which included training on the principles of care, safe working practices, record keeping and reporting concerns and safeguarding. Staff members spoken with confirmed that they received satisfactory training to undertake their work. The registered manager explained that training and development was linked to the home's service aims and to service users' assessed needs and individual care plans. Staff were found to be knowledgeable of the disabilities and specific conditions of service users, and were found to have skills in communication and in dealing with anticipated behaviours. The registered person ensured that formal supervision of staff took place. Information held with a selection of the personnel records showed that supervision covered various aspects of staff practice, the aims of the home and the staff member's personal development needs and requirements. However, we noted there to be some gaps in the training of some of the staff, and some staff explained that although there was a formal supervision policy, supervision was infrequent. We discussed this issue with the registered manager who confirmed that she had already identified this as an issue. She explained that measures were in place to ensure staff received update training and we saw documentary evidence to support this. We saw written evidence that staff supervision was now taking place more regularly and we were satisfied that appropriate measures were in place to address the issues.

Good

Is the service caring?

Our findings

Feedback from people about the attitude and nature of staff was positive. One person using the service told us, "Everyone here cares for me." A relative said, "The staff treat him like family. He is very settled and very well-cared for." Staff showed they cared for people by attending to their emotional needs. For example, one person was distressed and a care worker responded to the person. They talked with the person and asked how they were. They gave time for the person to talk and engaged with them"

We were told by staff at the home that no-one at the home used an independent advocate and that people had the involvement of family. We did see some information for people for people to use regarding local advocacy services within the reception area of the home. Advocacy was available to people if people had no family or friends to assist them, or if someone wanted an independent person to act on their behalf when discussing issues with others such as the care home, or local authority. People's bedrooms were personalised and contained photographs, pictures, ornaments and other items each person wanted in their bedroom. This showed that people had been involved in establishing their own personal space within the home. People at the home confirmed that family and friends were welcome to visit, and this was confirmed by a relative on the day of our inspection.

Staff confirmed they had received awareness training in end of life care. Information contained with the staff personnel records confirmed this. Nursing staff were involved in more specialised training that was on going. The registered manager explained that the aim of the home was to ensure that all residents received good quality end of life care. A member of staff explained, "The end of life care we provide allows us to have sensitive discussions with service users and relatives as end of life approaches. We make records on the co-ordination of care; care in the last days of life and also care for the bereaved." One nurse said, "We arrange for staff to be with people, until their family arrive. No one is left alone. If we need an extra member of staff we can do this. It's important for us to make end of life a time where people feel comfortable and at ease. This is difficult, but we try our best to make sure people have a comfortable passing." People were involved in decisions about their end of life care as much as possible. For example one person had a 'do not attempt cardio pulmonary resuscitation' (DNACPR) order document in place and a care plan giving details of their wishes at the end of life.

We observed care workers knock on people's doors before entering rooms and staff took time to talk with people. People were treated with dignity and respect by staff and they were supported in a caring way. Care workers used people's preferred names and we saw warmth and affection being shown to people. People recognised care workers and responded to them with smiles which showed they felt comfortable with them. Tasks or activities were seen not to be rushed and the staff were seen to work at the people's own pace. The arrangements for health and personal care ensured that people's privacy and dignity were respected. Personal care such as nursing care, bathing, washing, using the toilet or commode were carried out in private. One person confirmed that consultation with, and examination by, health and social care professionals was also carried out in private. Staff confirmed that they respect information given by people in confidence, and handle information about people in accordance with the home's written policies and procedures. On speaking with staff, it was clear that they knew when information given them in confidence

must be shared, for example, if allegations of abuse were made or if there was a suspicion of crime such as theft.

We looked at the ways in which people were supported to understand the choices they had that were related to their care and support, so that they could make their own decisions. We spoke to four people at the home who said they were comfortable when expressing decisions about their care. One person said that they could approach the staff or registered manager to discuss issues such as the food, clothing and medication. A number of people were unable to express views about their involvement in decision making, so we spoke to two relatives about this. One told us that they felt they could influence the care and support their relative received, and explained that they had been involved in significant decisions about their relative's healthcare. Another explained that they had been given the opportunity to have input into their relative's care plan, and had been consulted about changes to the care that had been provided. We found documentary evidence to support this in the care plans and risk assessments.

Requires Improvement

Is the service responsive?

Our findings

A relative told their family member received personalised care that was responsive to their needs. They told us, "It works for [person's name] because he's in a routine which he likes. That, and having staff he knows, reduces his anxiety and helps him to feel secure."

The people we spoke with said that the care they received was delivered in accordance with their needs and wishes, and the written reviews of this care supported this view. The reviews showed that where possible, the person themselves had been involved, and if this wasn't possible, family members and others important had been consulted. We spoke to one relative about the care planning process, and delivery of care, and they all were satisfied that the staff were following the guidelines set of in their relative's care plans, and that this had resulted in their relatives experiencing a good quality of life whilst living at the home.

The nurse in charge said that care staff reported and recorded any issues regarding people's health and well-being, and action was taken to deal with these issues accordingly, either via the nursing staff or through other agencies such as their GP. Staff confirmed that they were involved in supporting people with personal care and oral hygiene. The nursing staff were involved in assessing people who were at risk of developing pressure sores and appropriate intervention was recorded in people's care plans. The incidence of pressure sores, their treatment and outcome was recorded in people's files, and reviewed on a continuing basis. Equipment necessary for the promotion of tissue viability and prevention or treatment of pressure sores was provided.

The home had a suitable complaints policy and procedure that was publicised in its documentation provided to people who use the service. A record of complaints was kept and examined. We found that the organisation had liaised openly and honestly with complainants, and provided them with up to date and accurate information relating to their complaints. Action had been taken to satisfactorily deal with and resolve complaints.

Nutritional screening was undertaken on admission and subsequently on a periodic basis, and a record maintained of nutrition, including weight gain or loss, and appropriate action taken. Appropriate interventions were carried out for people identified as at risk of falling. The arrangements for health and personal care ensured that people's privacy and dignity were respected. Personal care such as nursing care, bathing, washing, using the toilet or commode were carried out in private. One person confirmed that consultation with, and examination by, health and social care professionals was also carried out in private.

The home had appropriate processes in place to ensure that when people were admitted, transferred or discharged, relevant and appropriate information about their care and treatment was shared between providers and services. Information held with people's personal care records showed that liaison had taken place with other health professionals and a relative spoken with confirmed that they had been involved with the assessment process and had been kept informed at every stage. We found written records to show that information was shared in a timely way and in an appropriate format so that people received their planned care and support. The nurse in charge explained that staff worked with other providers and professionals

such as district nurses, hospital staff and social workers, to ensure that people's care plans reflected their individual and diverse needs. This was documented. In the event of an emergency, we found details of how information would be shared with other agencies in a safe manner, so as to make sure people received a coordinated approach to support the need to meet the needs described in their care plan. Written records were maintained and appropriate external contact details were logged.

Staff told us that opportunities were given to people to take part in various activities. They said that that there were board games available to people to use, entertainers sometimes visited the home, and staff engaged in social chats with people. People living at the home said that there was plenty to do. Staff were seen to engage people in activities such as chatting, talking about the news, reading the newspaper and other activities. We noted that there was a younger person living at the who had a learning disability. The registered manager explained that this person spent almost all their time at the home, and did not have any outside contact with people of their own age, or groups that support people with a learning disability. The registered manager agreed to make enquiries to see of there were any social groups or services within the local area, that this person could get involved in. We have made a recommendation regarding this issue.

Information held within the care plans showed that people had been involved in their assessment of need to a lesser and greater degree, depending on their capabilities. This process helped to identify their individual needs and choices, and was based on information supplied by social workers and external healthcare staff. If the person was unable to contribute, information had been actively sought from others such as family members and friends. Written personalised care plans, which detailed people's individual needs and choices, had been put together by the staff and the person receiving the care where possible. We noted that the care files were very detailed, and some of the information about individuals was difficult to find and cross reference. The registered manager agreed that this was the case, and explained that she had a plan to improve the records so that information was more accessible. She also added that one page profiles relating to each individual living at the home were being produced so that staff could quickly see what people's needs were, the risks related to their care and what their interests are. We have made a recommendation relating to this.

We recommend that the registered manager make enquiries to see if there are any social groups or services within the local area, that individual service users can access to ensure that they are supported to engage in meaningful activities linked to the interests and assessed needs.

We recommend that the registered manager improve the way in which the care records are set out so that information is more accessible. The addition of one page profiles relating to each individual living at the home would allow staff to quickly see what people's needs were, the risks related to their care and what their interests were.

Good

Is the service well-led?

Our findings

One person using the service told us, "I'm happy here. I want to stay forever." A visiting relative said, "The atmosphere in the home is friendly and welcoming. It always feels like a well-run room. Another relative told us that the home's manager was always available to talk to.

The people we spoke with on the day of our visit (service users, staff and relatives) all said that the registered manager and management team provided good leadership. People said that the registered manager was knowledgeable, and that she was able to deal with issues in a positive manner as they arose. The staff we spoke with clearly understood the lines of reporting and accountability within the home. When we questioned staff they were able to give a good account of their roles and responsibilities with reference to keeping people safe, meeting people's needs and raising concerns regarding the quality of care provided at the home.

We saw a wide range of policies and procedures in place which provided staff with clear information about current legislation and good practice guidelines. This meant staff had clear information to guide them on good practice in relation to people's care. We found written evidence to show that the registered manager had an appropriate system in place used to assess and monitor the quality of the service. The registered manager explained that she, the registered manager and nursing staff were involved in auditing different aspects of the service provided. We saw evidence of these audits, and saw that the system had flagged up areas of concern, and minor issues relating to care delivery and service provision. These issues had been actioned, and dealt with appropriately. We found daily records to show that various people at the home had been involved in incidents that required notification to the Commission and/or the local Safeguarding team, and that notifications had been processed and sent in a timely manner.

The staff we spoke with confirmed that they received regular handovers (daily meetings to discuss current issues within the home). They said that handovers gave them up to date information to continue to meet people's needs, and updates regarding incidents, and what action to take to minimise or reduce the possibility of further accidents or incidents. One staff member told us, "Handovers are important." Staff at the home said that they had a clear vision for the home which involved providing care and support that was compassionate, dignified and safe.

We saw that annual management review meetings were held to analyse the performance of the service and review its objectives. We saw the agenda for the latest meeting which included areas such as; review of service users information, results of internal audits, resource needs, staff training and evaluation, client feedback and recommendations for improvements. The service had a business plan in place. This included the current management structure, objectives of the service which covered staffing, recruitment, meeting service users' needs, audits and service plans. We also saw a training and development plan and audit file. Surveys were sent out to all the people who received a service on an annual basis. The return rate for surveys was low, however, the comments were very positive. Any issues raised via the surveys were addressed via an action plan.