Oakfield Care (Ashtead) Ltd

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?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

This inspection took place on 22 January 2019 and was unannounced. This was the first inspection since the provider of the service had changed their registration with the CQC.

Oakfield Nursing Home is a 'care' home. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. The service can accommodate up to 29 older people. At the time of our inspection there were 27 people using the service the majority of whom were living with mental health support needs.

The house people lived in had a homely feel. A process of redecoration was underway at the time of the inspection to refresh the tired and dated décor.

People told us they felt safe living at Oakfield Nursing Home. Staff understood their responsibilities around identifying and reporting suspected abuse. People's support needs were regularly reviewed to identify the safe levels of staff needed to meet those needs. Robust recruitment processes ensured that before new staff worked at the home, they were safe and suitable to do so.

Hazards to people's health and safety had been identified, and management plans produced to reduce the risk of harm. The staff team kept people safe by reviewing accidents and incidents and acting to prevent reoccurrences.

Staff ensured that people received their medicines as prescribed, or when they needed them. Only those staff that were trained and competent could give people their medicines.

Infection control processes meant that the environment and equipment were routinely cleaned to keep people safe from the spread of infections.

A comprehensive assessment of people's needs was completed before they moved into the home. This ensured the staff had the skills suitable to meet those needs.

Staff received training and supervision to keep them up to date with best practice. Nursing staff were supported to maintain their registration, and take part in additional training as necessary.

People had enough to eat and drink. There were good links with the local health care services, so people had access to GP's and other health care professionals when needed.

People's rights under the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) were met. If a person could not make a specific decision for themselves people who had legal authority to make decisions for them where involved.

People were supported by staff that were caring, and respected their privacy and dignity. Staff knew the people they supported as individuals. People's faiths, culture and lifestyles were respected.

Care plans had a good level of detail to enable staff to give a responsive level of care. These were reviewed periodically or as people's needs change to ensure they reflected current support needs. People had access to activities that interested them, and they said there was always something going on to keep them entertained.

There was a complaints policy in place and the registered manager said complaints were welcomed as it gave them the opportunity to improve.

Systems were in place to support people who were at the end of their lives. Staff knew their preferences and choices so people could be assured of a dignified, and as far as possible, pain free death.

The owner and management of Oakfield Nursing Home's goal was to provide a family feel to the home. This is what we observed during the inspection, from the interactions between people, their families and the staff, and the way the management spoke about people.

Quality assurance processes ensured that peoples feedback was obtained and acted on, and that staff provided a good standard of care to people. Notifications of incidents had been submitted to the CQC in accordance with the regulations.

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.

People felt safe living at the home. Staff understood their responsibilities around protecting people from harm.

The provider had identified risks to people's health and safety with them, and put guidelines in place for staff to minimise the risk.

There were enough staff to meet the needs of the people. Appropriate checks were completed to ensure staff were safe to work at the home.

People's medicines were managed in a safe way, and they had their medicines when they needed them.

Is the service effective?

Good

The service was effective.

A program of redecoration was underway at the time of the inspection to improve the dated and tired décor.

Peoples needs had been assessed prior to coming to the home, to ensure those needs could be met.

Staff said they felt supported by the registered manager, and had access to training to enable them to support the people that lived there.

People had enough to eat and drink and had specialist diets where a need, or preference, had been identified.

People had access to health care professionals for routine check-ups, or if they felt unwell.

People's rights under the Mental Capacity Act were met. Assessments of people's capacity to understand important decisions had been recorded in line with the Act. Where people's liberty may be being restricted, appropriate applications for DoLS authorisations had been completed.

Is the service caring?

Good

The service was caring.

Staff were caring and we saw good interactions that showed respect and care. People were supported in a dignified way.

Staff knew the people they cared for as individuals. This included their preferences and how they wanted to live their lives.

People's right to practice their faith was respected and supported by staff.

Is the service responsive?

Good

The service was responsive.

People were involved in their care plans and their reviews. Care given reflected that as detailed in the care plans.

Staff offered activities that matched people's interests.

There was a complaints procedure in place.

People were supported at the end of their lives to ensure their needs and preferences were met.

Is the service well-led?

Good

The service was well-led.

Quality assurance checks had been effective at ensuring that people had received a good standard of care and support.

Feedback was sought from people via key worker meetings and annual surveys.

Staff felt supported and able to discuss any issues with the registered manager.

The registered manager understood their responsibilities with regards to the regulations, such as when to notify CQC of events.

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 inspection was a routine comprehensive inspection. This inspection took place on 22 January 2019 and was unannounced. The inspection team consisted of one inspector, an expert by experience and a specialist nurse advisor. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Prior to the inspection we looked at information we held including notifications we received from the service of significant events. We had asked the provider to send us an updated Provider Information Return. The PIR 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 review this information to see if we would need to focus on any particular areas at the service. We also contacted the local authority to seek their views on the care being provided.

We spoke with six people on a one-to-one or in small groups. We spoke with five relatives or visitors to the home. We also spoke with five staff which included the registered manager who was present on the day. We observed how staff cared for people, and worked together. We also reviewed care and other records within the home. These included four care plans and associated records, four medicine administration records, three staff recruitment files, and the records of quality assurance checks carried out by the staff and provider.

Good

Is the service safe?

Our findings

People and relatives were positive about how safety was managed in the home. One relative said, "She's safe here. They are very good to her."

People were protected against the risk of infection because the home environment was kept clean. There was a cleaning schedule in place and staff ensured that the rooms and equipment were kept clean. Staff were observed to wear appropriate personal protective equipment such as gloves and aprons when needed, for example when serving food. One area the provider may wish to review is with regards to staff being 'bare below the elbows.' This helps reduce the risk of spread of infection as staff can more effectively wash their hands as there is nothing to harbour germs or bacteria. Some staff were seen to wear jewellery and false nails which goes against current best practice around infection control.

Clinical areas were kept clean, and equipment such as mobility aids were routinely cleaned to make sure they were safe to use. There were no unpleasant odours in the home. This demonstrated that people's needs with regards to continence management and support were met, and the risk of spread of infection was minimised.

Staff understood their roles and responsibility about keeping people safe. This included understanding the signs of abuse, and the action they needed to take should they suspect it had taken place. One staff member said, "I have to tell the manager straight away. If they don't do anything I have to call the CQC." Policies in relation to safeguarding and whistleblowing reflected the local authority's procedures. Appropriate referrals to the local authority safeguarding team had been made when appropriate.

People were kept safe because the risk of harm related to their health and support needs had been identified and managed. Staff understood the risks to people and helped them where needed. People who were at risk of choking were supported when they ate and drank. Food and drink had been provided in the consistency recommended by health care professionals.

Assessments of the risk of harm to people included areas such as falls, moving and handling, and behaviour that may challenge. When risks had been identified, the care plans contained clear guidance for staff on how to manage these. For example, guidance on how to deal with people's behaviour in a positive way had been included in risk assessments. Staff were seen to treat people with respect, dignity, compassion and follow the guidance that reflected their behavioural support needs. Where people were at risk of falls safe working practices had been clearly documented. These included the use of walking frames, hoists and details of the specific slings to use.

Where people were at risk of skin damage, such as pressure sores, appropriate risk assessments had been carried out. Management plans were in place to reduce the risk of pressure damage to those at risk. For example, pressure relieving mattress were in place for two people who had been assessed to be of high risk of developing pressure sores. Although a number of people were at risk of pressure sores, no one had a sore at the time of our inspection, highlighting the safe care and treatment they had received.

The home environment had been regularly assessed for hazards and risk assessments put into place to minimise the risk of harm occurring. Areas covered included pest control (none found), fire safety, electrical safety and equipment safety. Regular fire drills took place and people each had an emergency evacuation plan (PEEP). This ensured staff understood each person's support needs in the event of an emergency. People's care and support would not be compromised in the event of an emergency. Information on what to do in an emergency, such as fire, was clearly displayed around the home and people took part in fire drills.

The registered manager reviewed accidents and incidents with a view to prevent reoccurrence. There had been very few accidents since our last inspection (under the previous provider) which demonstrated that risks to people were well managed. Where accidents had happened, action had been taken to minimise a repeat occurrence. For example, one person fell out of bed, and the registered manager immediately arranged for the bed to be changed.

Appropriate checks were carried out to help ensure only suitable staff were employed to work at the home. The management checked that potential staff were of good character, which included Disclosure and Barring Service (DBS) checks. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services. Staff's eligibility to work in the UK was also confirmed before they were employed.

There were sufficient staff deployed to keep people safe and support the health needs of people living at the home. The Home benefited from stable workforce. There were no staff vacancies and no use of agency staff, which gave consistence to the people that lived here. People and their families gave a positive answer when we asked if they felt there were enough staff. Staff were seen to be around all day in the sitting room where the people did activities and spent their day. We saw staff being available to help people who were in wheelchairs or using walking frames to get to the dining rooms for their lunch, or when taking part in activities. Call bells were also answered quickly, indicating staffing levels were sufficient to meet peoples needs.

Peoples medicines were managed and given safely as prescribed. Medicine was stored as per manufactures guidance, for example refrigerator temperatures were maintained at safe levels. Refrigerator temperatures were recorded regularly and staff had guidance on what to do in the event of the temperatures being outside of the recommended levels. The rooms where medicines were stored were free from clutter and maintained to a good standard. Staff were knowledgeable on safe storage practice. Medicines were stored safely in locked trolleys.

Staff who gave medicines had received training and their competency assessed before they could do this. Staff were aware of good practice regarding providing support with medicines. For example, ensuring people had preferred fluids to help them swallow, or seeking alternative formats for medicine from the GP. Medicine administration records (MAR) were clear and easy to read and had no signature gaps when medication had been administered. This ensured that the right people received the right medicine at the right time.

Good

Is the service effective?

Our findings

The house that people lived in was an old building that had been modified and extended over time. A visiting health care professional was heard to say to staff, "The home is lovely it has a really homely feel." While it had a warm and homely appearance inside, there were some improvements that could be made with regards to the decoration, which was tired was dated. The home environment and decoration were in the process of being updated at the time of our inspection visit. Adaptations had been made around the home to suit people's needs. Changes in floor level were covered by ramps wherever possible to reduce the risk of trips and falls. A lift was available for people who may not be able to manage the stairs. Some people smoked and they had access to a room where they could do this in a safe way.

The registered manager assessed the needs of people before they moved into the home to ensure the environment and staff would be able to meet their needs. This also gave the opportunity to check if any special action was required to meet legal requirements. For example, use of specialist medicines, use of equipment that lifts people, or meeting the requirements of the Equalities Act (such as not discriminating against people). This information was then integrated into care plans for staff to follow when the person came to live at the home.

Staff training and supervision ensured that people received effective care and support to meet their needs. Nursing staff said they had access to training and professional development and had support from the provider to maintain their registrations with their governing body, the nursing and midwifery council (NMC).

Ongoing training and refresher training was well managed, and the registered manager ensured staff kept up to date with their training. Training specific to the needs of people had also been given, such as in mental health. Staff had regular supervisions (one to one meetings with their manager) to discuss training needs, and give them the opportunity to discuss their role with their line manager. Observational supervision also took place over the year. This involved staffs practice being observed and feedback given on what they had done well, and any areas they may need to improve.

People had effective support to protect them from malnutrition and dehydration. Feedback about the quality of food was all positive. One person said, "'The food is good, plenty of it'. Another person said, "We get lots of tea breaks all afternoon. We get plenty of food here." The homes chef was seen to go into the lounge after lunch and ask if people had enjoyed their meals and if they had eaten enough. This feedback was then used to plan future meals, or liaise with care staff if people's needs and preferences had changed, so that these could be recorded in care plans.

Where people were at risk of malnutrition or dehydration food and fluid charts were in place. These recorded their food and fluid intake to ensure they maintained good health. People's weights were monitored. Referrals to professionals and fortified meals were used where required, such is in helping people gain, or maintain a healthy weight. Drinks and snacks were offered to people throughout the day of the inspection, with staff ensuring people had enough to eat and drink.

Staff teams worked well together so that people's needs were met. Clinical and care staff met during handover meetings to discuss how the day/night had gone, and if people had any additional needs, such as if they felt unwell. A diary was also in place highlighting any external visits / involvement on the day. The staff interviewed were aware of the residents needs and what required to be done with regards to additional support on the day of the inspection. This included ensuring people and staff were ready when external healthcare professionals visited.

People had access to health care professionals to help keep them healthy. People could see the GP if they felt unwell, and were supported to attend appointments at hospitals and specialist consultants when needed. Records showed when the GP had been called to review people's health, the reasons why a review had been requested and the outcome of the GP visit had been recorded. Records also showed when other healthcare professionals such as the optician and the chiropodist saw people.

The 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. Consent to care and treatment was sought in line with legislation and guidance.

Where people lacked capacity to make certain decisions, appropriate assessments had been completed to ensure the requirements of the Act were met. Discussions around power of attorney had been held and recorded so staff knew who could legally make decisions for peoples care and finances. Staff had an understanding of the Mental Capacity Act 2005 including the nature and types of consent, people's right to take risks and the necessity to act in people's best interests when required. Staff asked for people's consent before giving care and support throughout the inspection.

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 are called the Deprivation of Liberty Safeguards (DoLS). Where people's liberty was restricted to keep them safe, appropriate applications had been made to the DoLS Board. People were supported in accordance with these DoLS authorisations. Examples such as people not having the capacity to make a decision to live at the home had been addressed under the DoLS. The registered manager was also knowledgeable about the application of the DoLS. A DoLS assessor was on site during the inspection reviewing applications which demonstrated requirements of the MCA were met.

Good

Is the service caring?

Our findings

People and their relatives where positive about the caring nature of staff. One person said, "It's good. The staff are very nice, very approachable." A relative said, "The best thing is that there is no big turnover of staff. Only three or four staff have left in the eight years I've been coming here." Staff were also positive about working here. When asked what the best thing about the home was one staff member said, "The residents, I joke and laugh with them every day."

People were treated with kindness and compassion by staff. During the inspection we saw many positive interactions between people and staff. Physical interactions were gentle and kind, such as holding people's hands when staff sat with them. Staff took time to ensure people were listened to and their needs met. One person wanted to wear a particular item of clothing and staff went to get it for them. Staff held it up to them to check that what they had brought was what they wanted. When the person said it was not, staff went to get another item of clothing, until the person confirmed that was the one they wanted. Staff were patient with the person and at no time gave the impression that the person was being too much trouble.

Kindness and understanding of people's needs was demonstrated across the staff team. For example, during the redecoration of the home, maintenance staff were aware of how their work could impact on people. One staff member said, "I have to take into consideration people's needs, for example being aware of the impact that noises such as drilling could have on their mental health. We do some tasks at night to minimise impact to people such is when we are doing work in corridors."

People were involved in day to day decisions around their care and support. Staff asked people if they wanted dinner, and were given a choice of what to eat. Staff asked if people needed help, for example cutting up food, and didn't just assume or do it without asking. Staff were knowledgeable about people they supported. This included the jobs they had earlier in their lives, hobbies and interests, as well as medical support needs. Care records recorded personal histories, likes and dislikes, and matched with what staff had told us.

Staff treated people with dignity and respect. An example was seen where the activities person needed to get into a cupboard that a person's walking frame was placed in front of. Before moving the walking frame, they said hello to the person and asked if they could move their walking frame, explaining why. When the person nodded, staff moved the walking frame and continued to talk to the person while they looked for the items in the cupboard. This was important as the although the person was not able to verbally communicate staff still acknowledged and interacted with them. Staff showed respect to people in many ways. This included telling them when visitors arrived at the home, and who they were and ensuing people were supported when items of clothing became loose or soiled, to protect their dignity.

Each person was encouraged to do as much for themselves as possible at a level they would be able to manage. People were involved in some chores and the home, for example one person was seen to help lay the table at lunch.

Where people had faiths or cultural needs these were seen to be met. People had access to several religious centres in the community. A local church picked people up two to three times a week. The staff had arranged for the church to do this so people could practice their faith when they wanted. There were also regular visits by spiritual leaders to the home to carry out services for those that may not have been able to attend faith services in the community. For example, one person's faith had no centre in the local community. The registered manager had contacted the national centre for that faith and arranged for visitors to come to the home to see the individual so they could practice their faith together.

Good

Is the service responsive?

Our findings

People received personalised care that was responsive to their needs. One person said, "It's very nice, lovely place. The best thing is it's laidback, we can speak to the staff, watch TV, play games. I cannot think of anything that could be improved.' Another person said, "I'm very happy with everything."

Care plans were person centred and gave good information about the whole life of the person. They included detailed personal histories, as well as the individual care and support needs of the individual. The staff were aware of the people's needs and were observed giving the care with commitment and compassion. Care plans were updated bimonthly and involved people where ever possible to ensure the care had met their specific needs.

People had access to activities to stimulate their minds, keep mobile and offer opportunities to go into the local community. One person said, "I go out twice a week to do the shopping, with someone with me." Another person said, "'I like the activities - music, singing, quizzes. When the weather is nice they bring us tea on the patio." In the afternoon of the inspection there was singing, music, and a cake as it was one person's birthday. The staff sang and danced to the music and inviting people to get up and dance with them. People who were unable to stand were also seen to be involved, such as clapping their hands or tapping their feet to the music. One person with a walking frame walked into the room and joined in by moving their head to the music.

People were supported by staff that listened to and responded to complaints or comments. One person said, "I have never needed to complain about anything." Another person said, "Staff have time for me. They listen if I am unhappy." A family member said, 'The people who run it (the home) are very nice. Any feedback is face to face or on the phone. We keep in touch, it's not bad." Another relative said, "If I had a problem I would say it - like the water damage in my family members room. They do act on what we say. They are redecorating my family members room at the moment."

There was a complaints policy in place that was clearly displayed around the home. The policy included clear guidelines on how and by when issues should be resolved. It also contained the contact details of relevant external agencies, such as the Local Government and Social Care Ombudsman. There had been no formal complaints since the provider had changed their registration with us. During the same period of time many compliments had been received by the home.

People would be supported at the end of their lives. End of life plans were in place for those that had consented to have them completed. These covered people's faiths, type of funeral they would like, and where they would like to be if they became very ill, such as staying at the home or going to hospital. Where people were unable to give consent, the provider had followed the requirements of the Mental Capacity Act with regards to making best interests decisions, and involved families where appropriate. Any person who required end of life care would be referred to the community nursing services for care and intervention, supported by the local GP.

Good

Is the service well-led?

Our findings

People lived in a home that was managed by a family with a clear vision for the service. They wanted to provide a family feel to the care people received. A relative said, "I can honestly say that this was the best place for my family member. The manager is superb, so friendly and kind." Staff were seen to provide care in line with the vision of the owners, as detailed in the caring section of this report.

There was a positive, person focused culture within the home, which was reflected in our findings across all the five key questions that we asked. Staff were also positive about their roles and enjoyed their work. Staff understood their roles and responsibilities and felt supported by the registered manager. During the inspection we listened to conversations between the registered manager and staff and heard professional and respectful conversations.

Staff were aware of how to raise concerns. Staff we spoke with reported that the management was receptive to any staff feedback including those of concerns and/ or complaints. Staff spoke highly of the home management and said they received support from both the registered manager and fellow colleagues.

The providers quality assurance system ensured people received an overall good standard of care. Audits were completed on all aspects of the home. These covered areas such as infection control, health and safety, and medicines. These audits generated improvement plans which recorded the action needed, by whom and by when. Actions highlighted were addressed in a timely fashion. The provider also carried out an annual self-assessment that reviewed all aspects of the home and the service they provided.

People and those important to them were involved in giving feedback about how well they thought the home was managed. Due to people's support needs, group resident meetings did not take place. These were replaced by one to one meetings with their key worker. Topics such as food, activities and if they were happy were all discussed. This gave people the opportunity to raise any concerns, or offer suggestions to improve the service. Feedback was also sought from people's families, and health care professionals by the use of questionnaires.

Staff were involved in making improvements to the service people received. The provider and registered manager sought feedback via team meetings. These were also used as mini teaching sessions. Topics included responding emergencies and use of the newly introduced 'red bag' system. This ensured that when a person was taken to hospital key documents and personal items went along with them. This involved working closely with other agencies to ensure they were all aware of the system and its use.

The registered manager was aware of their responsibilities with regards to reporting significant events to the Care Quality Commission and other outside agencies. This meant we could check that appropriate action had been taken. They had also completed the Provider Information Return when it was requested, and the information they gave us matched with what we found when we carried out this inspection.