Mondial Care Ltd

Oakland 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?	Requires improvement
Is the service responsive?	Good
Is the service well-led?	Good

Overall summary

This inspection took place on 13 August 2015 and was unannounced.

Oakland Nursing Home is registered to care for up to 27 older people. On the day of inspection there were 24 people resident there. The home is located on the West Cliff area of Whitby within easy reach of the town's amenities and has passenger lift access to all floors.

The home had a registered manager in place. 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.

People told us they felt safe at the home. Risks to people were managed well without placing undue restrictions upon them. Staff were trained in safeguarding and understood how to recognise and report any abuse. Staffing levels were appropriate which meant people were supported with their care and to pursue interests of their choice. People received the right medicines at the right time and medicines were handled safely.

People told us that staff understood their individual care needs. We found that people were supported by staff who were well trained. All staff received mandatory

Summary of findings

training in addition to specific training they may need. The home had strong links with specialists and professional advisors and we saw evidence that the home was proactive in seeking their advice and acting on this.

People's nutritional needs were met and they received the health care support they required.

People were enabled to make choices about their meals and snacks and their preferences around food and drink were listened to and acted on.

The home was clear about its responsibilities around the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLs) and supported people to make informed decisions about their care.

Most staff had developed positive, respectful relationships with people and were kind and caring in their approach. However, we noted that a small number of staff could improve in this area so that all people received kind and caring attention at all times. The registered manager was aware of this problem and was addressing it through supervision, monitoring and the home's disciplinary procedure. People were afforded choices in their daily routines and their privacy and dignity was respected.

People were consulted about their care. People told us that most staff understood their needs and what was important to them and made sure that they received the care they needed and preferred.

People were assisted to take part in activities and daily occupations which interested them. People told us that they appreciated how staff had thought of ways to make sure they could continue with daily routines they enjoyed.

People were very well cared for in their final days. Health care specialists made comments about the good quality and compassionate care people received at this time.

People were encouraged to complain or raise concerns, the home supported them to do this and concerns were resolved quickly. The home used lessons learned to improve the quality of care.

There was good leadership which promoted an open culture and which put people at the heart of the service. Staff understood their roles and responsibilities which helped the home to run smoothly. Communication was clear from the manager to all levels of staff within the home. Staff were encouraged to give their views. The registered manager understood the home's strengths, where improvements were needed and had plans in place to achieve these with timescales in place.

Systems were in place to assess and monitor the quality of the service and the focus was on continuous improvement.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was safe.

People who used the service told us that they felt safe. The service managed risk so that people had the opportunity to live their lives without undue restriction.

Medicines were managed safely so that people were sure they received the right medicines at the right time.

Staff were safely recruited and were trained in how to safeguard people

Good

Is the service effective?
The service was effective.

People's needs were taken into account, including nutritional needs and staff were able to meet those needs.

Staff were well supervised. The registered manager supported staff to develop professionally through training which took account of the needs of people who lived at the home.

The registered manager was fully aware of the principles of the Mental Capacity Act 2005 and how to make an application to request authorisation of a person's deprivation of liberty.

The service ensured that people were supported to make decisions about their lives when their capacity may be impaired.

Good

Is the service caring?
The service was mostly caring.

Most staff treated people with kindness and respect, though a small number of staff could improve in this area so that people received kind and caring support at all times. The registered manager was addressing this issue through supervision, monitoring and the home's disciplinary procedure.

People's needs were known to staff and people were consulted about their needs and preferences.

People were involved in making decisions about their care.

Requires improvement

Is the service responsive?
The service was responsive.

People's care files put the person at the heart of care.

Staff assisted people to live their lives the way they chose to, which included supporting them to enjoy social and recreational activities of their choice.

Good

Summary of findings

The registered manager and staff acted promptly around people's health care needs and was proactive in seeking advice.

Is the service well-led?

Good

The service was mostly well led.

The culture was mostly supportive of people who lived at the home and of staff. However a small group of staff did not appear to uphold the culture and values of the service.

The lines of communication were clear and open, staff understood their roles and responsibilities.

The registered manager had made statutory notifications to the Care Quality Commission where appropriate.

There was an effective quality assurance system in place and staff were supported to improve their practice across a range of areas.

Oakland 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 inspection took place on 13 August 2015 and was carried out by one adult social care inspector. It was unannounced.

We had requested a Provider Information Return (PIR), however, the date for its return was not due when we inspected. The PIR 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 reviewed the information we held about the service, such as notifications we had received from the registered provider. A notification is information about important events which the service is required to send us by law. We planned the inspection using this information.

On the day of the inspection we spoke with four people who lived at the home, two visitors, the registered manager, a nurse, two care workers, a cleaner and cook. After the inspection we spoke with two health and social care professionals.

We spent time observing the interaction between people who lived at the home and staff.

We looked at some areas of the home, including some bedrooms (with people's permission), communal areas, the laundry room and office accommodation. We also spent time looking at records, which included the care records for four people. We looked at the recruitment, supervision and appraisal records of three members of staff, a full staff training matrix and other records relating to the management of the home.

Good

Is the service safe?

Our findings

People told us that they felt safe and that the staff and management responded to concerns they may have, for example by approaching people's behaviour which may challenge in a way which made them feel secure. For example, one person told us, " Sometimes [one person] makes a lot of noise but staff are always straight there so I feel okay about it." Everyone we spoke with told us that if they ever felt unsure about their safety, staff would reassure them and deal with what was troubling them.

Safeguarding training for staff was up to date with a clear timescale in place for when updates were required. Staff were able to describe different types of abuse and what action they would take if they observed an incident of abuse or became aware of an allegation. Staff told us they felt the team would recognise unsafe practice and report it to the registered manager. This meant that staff had the knowledge to protect people appropriately.

Care plans identified a person's level of risk. People who lived at the home and visitors told us that each area of risk had been discussed and agreed with them and we saw records which confirmed this. For example, we saw risk assessments for pressure care which recorded how a person liked to have pillows arranged to support them, and another for safety in the home which recorded consultation with the person around leaving the building. Where appropriate risk assessments included such areas as nutrition, pressure care, mental capacity, infection control, falls, behaviour which may challenge others, moving and handling and self- administration of medicines. Risk assessments were proportionate and included information for staff on how to reduce identified risks whilst avoiding undue restriction.

Staff told us that their approach to risk was responsive to people's changing needs and mental capacity. They told us that the home had a flexible approach towards managing risk which took account of people's day to day fluctuations of care needs. For example, one member of staff told us that a person might require two people to assist with moving on one day, but that on another with support and encouragement they may manage with only one.

Staff told us that people's behaviour which others might find challenging was managed with a positive attitude. One member of staff said, "We have regular contact with the community mental health team so that we are advised about strategies to keep people safe." They described choosing a time which was suitable for one person's mental health to go for a walk along the seafront or to visit a local café.

We saw that the home regularly reviewed environmental risks and carried out regular safety audits. We noticed that the environment was clear of obstructions, there were suitable hand rails and moving and handling equipment on each floor so that people could safely move around the home.

Staff application forms recorded the applicant's employment history, the names of two employment referees and any relevant training. We saw that a Disclosure and Barring Service (DBS) check had been obtained prior to commencing work at the home and that employment references had also been received. This minimised the risk of employing people who were unsuitable to work with vulnerable people.

People told us that they felt there were sufficient staff on duty to assist them. One person told us,

"There are usually enough people about and they will always come to help if you ask." The registered manager told us that inexperienced staff were on rota with skilled and experienced staff who could support them and staff confirmed this. We found that during the day there were at least five care workers on duty which included one nurse plus the registered manager and ancillary staff such as the cook. Staffing reduced to three care workers in the afternoon which included a nurse and two waking staff at night. Staff told us this felt safe for them. We observed that there were enough staff to attend to people's needs and to be relaxed with them during our inspection visit. The registered manager told us that staffing levels were responsive to changes in people's needs. For example if a person wished to go out for a walk or to the local café then staff were made available to do this.

The home had a policy on whistle blowing. Staff told us that they understood the whistle blowing procedure and were confident to raise any whistle blowing concerns.

We looked at the way in which medicines were managed. The home had a policy on the safe handling of medicines. Staff told us they were aware of this and we saw that they had up to date training so that they could handle medicines safely. The home used a Monitored Dosage

Good

Is the service safe?

System (MDS) with medicines supplied by a local chemist. A MDS is where medicines are pre-packaged for each person. We saw that medicines, including controlled drugs were recorded on receipt, administration and disposal. Recording for a chosen sample across one full day was accurate with correct coding used. Medicines which required refrigeration were stored appropriately and we saw that medicines were dated on opening when required.

All medicines including those which were not in the MDS were regularly audited and any anomalies in recording were addressed with staff in one to one sessions and in meetings. We saw examples of medicine audits. The registered manager and staff explained how the results of audits were used to support staff to improve the safety of their practice.

A visitor told us they were regularly involved in the review of their relative's medicines. Records of care planning reviews confirmed this. This was to ensure medicines were suitable and safe for the individual's current needs. Staff were knowledgeable about individual's needs around medicines and any associated risks.

We saw records of training in infection control which were all up to date. Clear timescales were recorded for when this needed to be updated. We visited the laundry room and saw that clothes were handled in a way which prevented the spread of infection. However, we noted that the laundry flooring required re treating to reduce the risk of cross infection.

We received an anonymous concern on the day of inspection that staff did not always use appropriate protective clothing to prevent the spread of infection; however we did not observe any evidence of this. We spoke with a health care professional about this, and they told us they had observed that staff did use protective wear in line with infection control good practice. We asked two members of staff about infection control and they understood what good infection control practice was. They referred to the use of aprons, gloves and the importance of hand washing when giving personal care to people.

Good

Is the service effective?

Our findings

People told us that staff were skilled in caring for them. One person told us, "They understand to put me on this cushion to help me stay comfortable." Another person told us, "They are very quick to get the doctor; I never have to ask twice." People said that staff explained things clearly to them. We saw that staff communicated with people at a pace and in a manner which helped them to respond.

We looked at staff induction and training records. Staff told us that they had received induction before they began their mandatory training. During this time they developed a good understanding of each individual's care needs and the philosophy of the home. Staff were knowledgeable about the needs of the people they supported and knew how people's needs should be met.

Staff told us that new employees spent time shadowing a more experienced member of staff before they were permitted to work alone. This was to make sure they understood people's individual needs and how risks were managed.

In addition to mandatory training, which was all completed as required, staff received specially sourced training in areas of care that were specific to the needs of people at the home. For example, a number of staff had received training in dementia care and specialist advice on end of life care through the hospice.

Staff told us that they received regular supervision and appraisals and we saw evidence of this in the staff records we reviewed. Staff told us this supported them to develop professionally and gave them support to give people the care they needed.

The home had links with specialists, for example in diabetic care, nutrition, sight and hearing, pressure care, continence care and the speech and language therapy team (SALT). This helped them to offer appropriate and individualised care. We saw that referrals for specialist input had been made promptly in discussion with each person where this was possible. A heath care professional told us, "The manager knows each of the people living there very well, I recently placed a person at the home and the staff gave them really excellent clinical care."

People told us they enjoyed the meals, for example, "The food is fine. I can always ask for what I want." A visitor told us, "They are good at trying to encourage (my relative) to eat, and they don't rush. The food always looks good and sometimes I eat with (them) here."

Care plans included information about how people were involved in decisions about their meals and drinks. People had been consulted about the menu and the choices were regularly adapted in line with their preferences. Those people who did not choose from the menu were offered alternatives. People's nutritional needs were assessed and the Malnutrition Universal Screening Tool (MUST) was used. MUST is a five step screening tool which is used to identify adults who are at risk of malnutrition. When people were assessed at risk they had strategies written into care plans, such as providing fortified foods or pureed diets. A health care professional told us that the home consulted with them around people's nutritional needs and their advice was followed.

We observed a morning drink time, with a choice of hot and cold drinks and snacks. Staff showed that they understood people's preferences and they listened and acted on what people asked for. We noted that people who asked for drinks also received them between these set times. Staff used charts appropriately when people required their fluid intake to be monitored. Care planning documentation and charts complemented one another so that it was clear how people's needs were met in this area of care. Reviews and decisions made about nutritional care were clearly recorded with people's involvement wherever possible.

The Care Quality Commission monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. DoLS are part of the Mental Capacity Act 2005 (MCA) legislation which is designed to ensure that any decisions are made in people's best interests. The registered manager told us that a small number of applications had been made to the local authority for deprivation of liberty safeguards to be put in place, but that nobody had yet been assessed as being deprived of their liberty.

Training records showed that staff had received detailed up to date training on DoLS and the MCA. Care staff were clear on the process for DoLS and mental capacity assessments as well as best interests decision making and the implications of lasting power of attorney. The registered

Good

Is the service effective?

manager understood the implications of the recent Supreme Court ruling which had clarified the notion of deprivation of liberty for people in a care home setting. This meant that people could be protected regarding their mental capacity.

People told us they were regularly asked for their consent to care. We observed that staff routinely asked for people's consent before giving assistance and that they waited for a response. When people declined, staff were respectful and returned to try again later if necessary. Care records showed that people's consent to care and treatment was sought. Staff told us how they looked for consent when people were not able to give this verbally, for example, through observing body language or facial expressions. This meant that the home consulted people about their care.

Requires improvement

Is the service caring?

Our findings

Most people told us that the staff and the registered manager showed them concern, gave them time and listened to them. For example, one person told us, “They are kind and they listen to what I want.” People told us that staff responded when they asked for help. One person told us, “They smile and stop to hear what you say.”

However, others told us that a small proportion of staff sometimes appeared too busy to listen to them. We received feedback from a person who visited the home, saying that a small proportion of staff were sometimes abrupt with them, and were not always as welcoming as they would like. One person told us that they had visited the home when they were looking for a care home for a relative but decided against pursuing their enquiry because the member of staff who greeted them at the door was impolite. We received an anonymous concern about one member of staff swearing in the hearing of people who lived at the home. We saw that the registered person had spoken with all staff at a recent staff meeting about politeness and taking care around the language they used while they were in the home. This meant that people did not always experience a caring and compassionate atmosphere. The registered manager was aware of this difficulty and was addressing the problem through supervision, monitoring and the home’s disciplinary procedure.

We spent time with people in the communal areas both in the morning and then again later in the day. We noted that staff interactions were more task orientated in the morning and that staff did not often ask how people were or stop to engage people in conversation during this time. When we overheard staff talking they were always polite with people who lived at the home. In the afternoon staff appeared more relaxed and had time to chat and they encouraged people to express their views and listened to their responses.

Staff told us that they did have more time to spend with people once they had completed their personal care tasks in the morning. They told us that they made sure that people who had difficulty communicating were enabled to give their views and that they gave people time, observed their body language and consulted with those who were close to them to ensure they understood them. Staff told us that they respected people’s privacy and dignity. They spoke about knocking on doors before entering private rooms and about how to offer personal care in a respectful way.

Some people had Do Not Attempt Resuscitation (DNAR) forms in place, and where we saw these they were correctly completed and regularly reviewed. People’s wishes for the end of their lives were also recorded for some people, and where this had happened the level of recording was detailed and gave guidance for staff so that people’s wishes could be followed. The registered manager told us that they approached the timing of end of life discussions with sensitivity and that some people preferred not to discuss this area of their care. When this was the case, this was respected in line with people’s wishes.

Staff told us about the way people were cared for in their final days. They emphasised the need for close liaison with end of life care professionals and attentive monitoring to ensure people did not suffer pain. We saw that people’s needs in relation to pain were addressed in their care plans and that nursing staff had attended syringe driver pain relief training, so that this type of pain relief was available to people who needed it.

We spoke with a health care professional who specialised in care for people who were reaching the last days of their lives. They told us that the staff at the home provided excellent compassionate and caring support for people who were in the later stages of life. They mentioned one person in particular and told us, “The person had good quality care and I believe they had a good death due to the compassionate care from staff at the home.”

The home worked closely with the local hospice which had recognised the home as one which supports, “high quality palliative and end of life care.” The home had a current certificate to this effect which had been presented to them by the hospice.

Good

Is the service responsive?

Our findings

We found that staff gave care in a personalised way. People were involved in their care plans and reviews when their needs changed and people's comments were written into the review documents. People signed care plans when this was possible and told us that their care was discussed with them. Staff told us they had spent time with people to compile a "This is Me" document. This gave details of people's personal history, their preferences and dislikes, important relationships and interests and was completed from the perspective of the person who was receiving care.

People's control over their lives was improved through the use of manual handling aids such as stand aids, which supported people to maintain their independence. One person told us, "I can manage to stand up with the use of the aid, and I have one on each floor of the home, so I don't need to take one with me."

People were supported to follow their interests, for example, one person enjoyed the local library service which visited the home, another person enjoyed having a walk out along the cliff path overlooking the sea with staff. Some people enjoyed the professional musical entertainment which was arranged in consultation with them. One relative told us, "They recently had a guitarist who was really good and who played a lot of the songs we love. There were some lovely tunes which left us with a tear in our eye."

The music entertainer also involved people who wanted to join in with percussion instruments. Staff told us that they had time usually in the afternoons for nail and hand care, jigsaws, looking at photographs and other one to one activities such as going out to a local café or to the shop. When people had particular interests the staff told us they would support people to take part. For example, one person was supported to take part in art work and one person had one to one support at all times to ensure that they always had an activity to engage in of their choice. We saw that this support was taking place.

The staff and most people we spoke with told us that the home usually welcomed visitors, though one person told us that they had not felt welcome on one occasion. During the day of our inspection we noticed that there were a number of visitors who were welcomed by staff.

People told us that the staff supported people to maintain their relationships. For example, they would assist people to visit one another in their rooms, make visits into the local community and invite relatives for meals at the home. A visitor told us that they were encouraged to take some meals with their relative and they enjoyed doing this.

A number of people remained in their rooms for most of the day when they were unwell or if they preferred this. Most people had their own TV's or radios, and staff told us they made a point of visiting people in their rooms so that they did not feel isolated.

People told us they were encouraged to express any concerns or complaints they might have and two people told us of times when they had discussed some area of concern to have it resolved politely and to their satisfaction. We saw that the service had a complaint procedure and that people's concerns had been dealt with and recorded, along with any learning points for future care.

Good

Is the service well-led?

Our findings

The people we spoke with confirmed that efforts were made to hear and act on their views. One person told us, " They ask us about what we want to do and what we think about things." Another person told us, "I think (the registered manager) is lovely, so kind and helpful."

Evidence of consultation with people and other interested parties was recorded on review notes and surveys. People who lived at the home and visitors told us they liked the registered manager and that they considered them to be conscientious and hard working. A health care professional told us, "The manager lives and breathes the home, they are 100% dedicated."

Staff told us that the registered manager was approachable and supportive and that they were

keen to listen to them and take their comments on board. The registered manager worked alongside staff so that any areas of concern could be quickly resolved.

Staff told us that the registered manager actively sought their views both in meetings and

informally, and that suggestions were appreciated and encouraged. Nursing staff were consulted about their views on medical care. The registered manager and staff spoke about looking for ways to continually improve the quality of life for the people who lived at the home. Staff told us they felt valued and that their views were respected.

However, we noted that a small group of staff did not always uphold the values and ethos of the home. These staff did not always display professional respect for one another or maintain an open and positive approach to service users and visitors at all times. The provider and registered manager were aware of this difficulty and was addressing the problem through supervision, monitoring and the home's disciplinary procedure.

The registered manager actively sought the views of specialist health and social care professionals and we had positive feedback from these professionals, telling us that their advice was acted on for the benefit of people who lived at the home.

The registered manager told us that the provider offered support in their role and visited the service to speak both with them and staff on a regular basis.

Staff understood the scope and limits of their roles and responsibilities which they told us helped the home to run smoothly. They knew who to go to for support and when to refer to the registered manager. They told us that mistakes were acknowledged and acted on and that staff were made to feel they could be honest about areas which could be improved.

The registered manager told us how they updated their knowledge and practice with information from organisations recognised for advising on best practice. For example, They used the Gold Standard Framework, for quality care at the end of life. This had contributed to a personalised approach to care planning. The registered manager also used the framework provided by St. Catherine's Hospice around, "supporting high quality palliative and end of life care." The service had achieved all seven quality stars awarded by the hospice for their end of life care delivery.

Communication with relatives and other interested parties was promoted through informal and formal meetings and questionnaire surveys.

The service sent notifications to CQC as required.

The registered manager carried out a range of safety and quality audits which were clear and easy to understand. Actions plans had been drawn up in relation to any identified improvements and staff had been informed of these in staff meetings. We saw records of improvements made as a result of the actions plans, for example in infection control and medicine administration.