Kingsley Care Homes Limited

Four Oaks Care Home

Inspection report

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Partington
Manchester
Lancashire
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19 July 2017

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection took place on 19 July 2017 and was unannounced. Four Oaks Care Home is a purpose built home for up to 62 people who require nursing or residential care. It is situated over two floors, with passenger lifts and has pleasant grounds and a car park. At the time of the inspection there were 48 people using the service.

There was a manager in place who was in the process of registering with the Care Quality Commission. 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. Toiletries were not stored safely and could have potentially caused harm to some people who used the service. Actions were taken immediately this was identified, to ensure people's safety.

Recruitment was robust to help ensure staff were suitable to work with vulnerable people. Staff rotas evidenced good numbers of staff.

Safeguarding policy and procedures were in place and staff we spoke with demonstrated an understanding of safeguarding issues and were confident to report any concerns. Accidents and incidents were logged appropriately and analysed for patterns and trends.

Health and safety information was in place and up to date. Medicines were managed safely at the service and staff were trained appropriately.

Staff induction was thorough, training was on-going and staff supervision sessions took place regularly.

Nutritional and hydration records were in place, but were not all complete and up to date. The mealtime experience was good and a number of choices were offered with regard to food and drink.

The service was working within the legal requirements of the Mental Capacity Act (2005) (MCA) and the Deprivation of Liberty Safeguards (DoLS).

We observed care throughout the day and saw that interactions between staff members and people who used the service were friendly and respectful. People's dignity was respected and care was offered and given discreetly and sensitively.

Residents and relatives meetings took place on a regular basis. Information was given to prospective users of the service and their families.

Advanced care plans, where the person's wishes for when they were nearing the end of their lives had been expressed, were included within the care files.

Care files we looked at evidenced that care was person-centred. There was a range of health and personal information and people's preferences, likes and dislikes were recorded.

There was an appropriate complaints policy and people felt able to raise concerns if they needed to. Compliments had been received from relatives in the form of thank you cards and letters.

The manager had been in place for a short time and had made some improvements to the service.
The manager was described as approachable by staff and relatives and staff members told us they were well supported.

We saw minutes of staff meetings, which were undertaken regularly.

Audits were undertaken regularly by the service. Audits for issues such as accidents and incidents were analysed to look at how continual improvements could be implemented. Reviews of care plans were undertaken but were not robust enough and had not always picked up inconsistencies in the records.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

People told us they felt safe at the home. Toiletries had not been stored safely in the home and could have caused harm to people who used the service.

Recruitment was robust and staff rotas evidenced good numbers of staff. Safeguarding policy and procedures were in place and staff we spoke with demonstrated an understanding of safeguarding issues and were confident to report any concerns.

Accidents and incidents were logged appropriately and analysed for patterns and trends. Medicines were managed safely at the service.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff induction was thorough, training was on-going and staff supervision sessions took place regularly.

Nutritional and hydration records were in place, but were not all complete and up to date. The mealtime experience was good and a number of choices were offered with regard to food and drink.

The service was working within the legal requirements of the Mental Capacity Act (2005) (MCA) and the Deprivation of Liberty Safeguards (DoLS).

Is the service caring?

Good

The service was caring.

Interactions between staff members and people who used the service were friendly and respectful. People's dignity was respected and care was offered and given discreetly and sensitively.

Residents and relatives meetings took place on a regular basis.

Information was given to prospective users of the service and their families.

Advanced care plans, where the person's wishes for when they were nearing the end of their lives had been expressed, were included within the care files.

Is the service responsive?

Good

The service was responsive.

Care files we looked at evidenced that care was person-centred. There was a range of health and personal information and people's preferences, likes and dislikes were recorded.

There was an appropriate complaints policy and people felt able to raise concerns if they needed to. Compliments had been received from relatives in the form of thank you cards and letters.

Is the service well-led?

Requires Improvement

The service was not always well-led.

The manager had only been in post for a short time and had made some improvements to the service.

The manager was described as approachable by staff and relatives and staff members told us they were well supported. We saw minutes of staff meetings, which were undertaken regularly.

Audits were undertaken regularly by the service. Audits for issues such as accidents and incidents were analysed to look at how continual improvements could be implemented. Reviews of care plans were undertaken but were not robust enough and had not always picked up inconsistencies in the records.

Four Oaks Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked 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 took place on 19 July 2017 and was unannounced. The inspection was undertaken by two adult social care inspectors from the Care Quality Commission (CQC).

Prior to the inspection we looked at information we had about the service in the form of notifications, safeguarding concerns and whistle blowing information. We also received a provider information return (PIR) from the provider. This form asks the provider to give us some key information about what the service does well and any improvements they plan to make.

During the inspection we spoke with six people who used the service and six relatives. We had been contacted by one relative prior to the inspection and were contacted by another two following the inspection. We also spoke with the manager, the regional manager, the clinical manager, the activities coordinator, two nurses and three members of care staff. We spoke with a visiting health and social care professional who was at the home on the day of the inspection. We reviewed records at the home including six care files, six staff personnel files, meeting minutes, training records, health and safety records and audits held by the service. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

Requires Improvement

Is the service safe?

Our findings

We asked if people felt safe at the home. They said they did and one person told us, "I am very happy here. I am comfortable and well looked after and I feel safe. The staff look after us very well".

We looked at six staff personnel files to see if there was a safe system of recruitment in place. The staff files contained proof of identity, application forms that documented a full employment history, a medical questionnaire and two professional references. Checks had been carried out with the Disclosure and Barring Service (DBS).The DBS identifies people who are barred from working with children and vulnerable adults and informs the service provider of any criminal convictions noted against the applicant. The safe system of recruitment helps to protect people from being cared for by unsuitable staff.

We looked at staff rotas which evidenced good numbers of staff. There were three nurses, one on each floor and a floater, five carers on each floor and one carer on one to one observations with an individual who required this level of care. There was also a chef, kitchen assistant, three domestics and a laundress. On nights there were two nurses, three carers on the upper floor plus the carer delivering one to one support and two carers on the ground floor. On the day of the inspection, in addition to the manager, there was a deputy manager and activities coordinator on duty.

The manager showed us the dependency tool the service was currently trialling to help ensure sufficient staff were on shift. On the day of the inspection we observed that staff were available to meet the needs of the people who used the service. We noted that one individual who required one to one support due to behaviour that challenged the service was receiving this. The manager told us the higher management team were supportive with requests for extra staff when required. The manager also told us they were careful when assessing potential new users of the service to help ensure the level of need could be met.

A health and social care professional we spoke with told us, "There are enough staff around. I have never had trouble finding staff". However, a significant number of relatives and staff felt there were not enough staff in the home at times and visitors said staff were particularly thin on the ground at weekends. Some relatives told us staff sometimes rang in sick at the last minute, leaving the home short for the day. They felt this led to their loved ones being left for long periods of time without any assistance should they require it. We discussed this issue at length with the manager and about the need to continue to monitor staffing levels and ensure these were sufficient at all times, especially as the home began to fill to capacity.

There was a safeguarding file which included an up to date policy and procedure, overview of incidents and referral forms. All safeguarding incidents had been reported appropriately to relevant agencies. We saw that incidents had been followed up and actions recorded. The training matrix evidenced that staff had either undertaken safeguarding training or were booked on training soon and those we spoke with were able to tell us what action they would take if abuse was suspected or witnessed. There was a whistle blowing policy and information on how to report any concerns around poor practice was on display in the home.

The home had an infection prevention and control file which included the policy and procedure, flow charts

and guidance around how to deal with potential outbreaks. All relevant contacts were included within the file. On walking around the home we found it was clean, uncluttered and fresh. There was one area where we detected a malodour. This was discussed with the manager and the regional manager. They were aware of the problem and plans were already in place to remove the carpet and replace it with more suitable flooring in this particular area. Personal protective equipment (PPE), such as plastic aprons and gloves, were worn by staff when undertaking personal care tasks.

We looked to see how the medicines were managed. The service used the Biodose system. This is where medication is stored in a pod. Each pod contained either tablets or liquid. There was photographic identification on the front of each person's tray, this helped minimise medication mistakes. We saw medication was checked before being offered to people and then recorded on the individual's medication administration record sheet (MARs). We saw that medicines including controlled drugs were securely stored. Controlled drugs were recorded in the controlled drugs register. The clinical lead was the designated person responsible for the ordering, receiving and disposal of medication. Medicines errors were recorded appropriately and actions taken to reduce the risk of further errors occurring.

We discussed with the nurse and clinical lead about the recording of prescribed thickening products for some people who had swallowing difficulties. Not all drinks were being recorded as having the thickening agent added. During the inspection a form was devised and immediately implemented to ensure all drinks would be recorded going forward.

The care records we looked at showed risks to people's health and well-being had been identified, such as risk of choking and the risk of developing pressure ulcers. We saw that appropriate action had been taken to help reduce the identified risks and the care records were updated to reflect any changes.

Records showed that general risk assessments were in place for areas of the environment and policies and procedures were in place in relation to ensuring compliance with health and safety regulations. We saw that equipment and services within the home had been serviced and maintained in accordance with the manufacturers' instructions. The home had a maintenance person to undertake regular checks and the up keep of the general environment. Monthly pest control checks were carried out. This helped to ensure the safety and well-being of people living, visiting and working at the home.

We looked around the home and found on the first floor where people were living with dementia in some of the en-suite facilities people had access to toiletries and in some rooms razors were easily accessible. This potentially posed a risk of harm to those people. We discussed this with the manager and the regional manager who confirmed that bathroom cabinets would be ordered immediately and in the interim period action would be taken to eliminate any risk. Evidence that toiletries had been placed in baskets with people's names on and locked away in a cupboard was supplied immediately after the inspection and individual cabinets were ordered straight away.

We saw procedures were in place for dealing with any emergencies that may occur such as utility failures. Personal emergency evacuation plans (PEEPs) had been developed and were held in the reception area. A PEEP provides the fire service with information needed to assist people who used the service to a place of safety and if any equipment was required. We saw that fire checks had been carried out and on the day of the inspection fire exits were clear of any obstructions.

Requires Improvement

Is the service effective?

Our findings

We spoke with a visiting health and social care professional. They told us, "They [the service] manage challenging service users very well and communication is really good. The home is proactive and do things without being pushed, for example, referrals to other agencies. The nurses are always helpful and keep you informed. I am always given the information I need".

There was evidence within the staff files we looked at of a robust induction procedure. This included mandatory training, reading policies and procedures, health and safety procedures and orientation around the home.

Staff training was on-going and the training matrix evidenced that all staff had undertaken training in fire awareness, first aid, duty of care, dignity and respect, safeguarding, dementia, nutrition, manual handling. Other training had been undertaken by some staff and was booked for others in the near future. This included catheter care, behaviour that challenges and continence.

Supervision sessions were completed on a regular basis and appropriate records completed. Supervision meetings help staff to discuss their progress at work and any learning needs they have. Some staff we spoke with felt they had lacked direction and motivation, due to a number of changes of manager. We spoke with the manager about this and she told us she planned to speak with staff and support them with development around promotion opportunities and the implementation of champions for particular areas of care.

Care plans we looked at included relevant health information and were clear and easy to follow. Risk assessments for issues such as falls, general health, behaviour and continence were in place. There were body maps in place to indicate any injuries or marks on the body. We saw that where issues had been identified with regard to, for example, weight or blood pressure, monitoring was undertaken. However, although some records were complete, others were inconsistent and the frequency with which monitoring should be carried out was unclear.

Nutritional information was included within the records and special dietary requirements were noted. Records showed that where concerns had been raised with regard to risk of inadequate nutrition and hydration, food and fluid charts were in place to monitor people's daily intake. However we found some charts had not been completed as required. This was discussed with the manager and regional manager who immediately sent staff around the home to check on the recording of people who were on food and fluid charts. Group supervisions were actioned following our inspection to address this recording issue. We saw actions had been taken with regard to referrals to other agencies, such as dietician or Speech and Language Therapy team (SALT).

The home provided care and support for people living with dementia. There was signage around the home to help people with orientation around the home. We saw that people's bedroom doors had room numbers on them and a picture of the person to them recognise their own room. There was good natural and electric lighting, with large low windows to allow people to see outside. There were a number of seating areas and

lounges on each unit so people who used the service were able to sit in areas of their choice.

We checked to see if people were provided with a choice of suitable, nutritious food and adequate hydration to ensure their health care needs were met. We saw that people were offered a choice of food at each meal. The day's menus were displayed in the dining rooms. We saw throughout the day people were offered a choice of hot and cold drinks and snacks. We saw people had jugs of juice or water in their rooms. There were satellite kitchens on each unit to enable people who used the service, staff and visitors to make refreshments.

We observed the lunchtime meal in one of the dining rooms. The tables were set nicely, with cloths, a flower in a vase and napkins. There was a menu written on a blackboard and people had already made their choices of food. However, they were asked again what they wanted and several had changed their minds. Three people wanted sandwiches which weren't on the menu and one person wanted cheese on toast. These requests were granted immediately and the alternative food was brought from the kitchen. Two people requested different meals for tea time and these requests were also agreed to. People who required assistance with their meal had been assisted first and staff were patient and kind with everyone. Conversation was pleasant and flowed easily and there was appropriate music playing quietly in the background.

We asked people if they enjoyed the food at the home. Two people who used the service told us they were happy with the choice of food. One said, "The food is lovely, plenty of choices. If there is nothing on the board that you fancy they [staff] will always get you something else". Another person spoken with told us, "I find the food is very good there is plenty of choice. The food is very tasty, I have no complaints".

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 so that they can 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. There were very clear documents held within the care plans which outlined people's level of understanding and capacity with regard to decision making. We saw clear evidence of best interests decision making. It was evident within care files that issues of consent had been discussed with people who used the service and with relatives. Consent for care, treatment, sharing information and the use of photographs had been obtained either from the person who used the service or their relative. We observed verbal consent being sought by staff throughout the day, for care delivery and support.

There was a DoLS file which included all authorisations and applications. The manager checked these monthly to ensure renewals were applied for in a timely manner. There were records within the care plans of why a DoLS had been put in place. Any DoLS conditions were noted and the manager told us she would implement care plans with regard to DoLS so that staff were clear about any conditions. Staff had undertaken or were booked on to training in MCA and DoLS and those we spoke with had an understanding of the principles.

Good

Is the service caring?

Our findings

People who used the service were complimentary about the staff. Comments included: "All the staff are lovely, they work so hard" and "I couldn't ask for better care". One relative said, "Staff are superb". Another said, "About eighty percent staff have their heart in the right place, but struggle to deliver care due to insufficient staff numbers". Other comments included; "There are some lovely staff"; "My [relative] is very settled and happy with the familiar faces around him. It is a lovely home".

We did receive some negative feedback from relatives, which was around inadequate staffing levels and we discussed this with them. Relatives told us some of their concerns were from before the present manager had been appointed and they felt quite unsettled as there had been a number of managers at the home who had not stayed. We discussed the issues with the manager who was aware of the concerns and agreed to speak with relatives to try to provide some reassurance that she would be staying at the service.

We saw people looked well groomed, well cared for and wore clean and appropriate clothing. Ladies had their hair done and gentleman were clean shaven. We noticed that attention had been given to nail care.

Throughout the day we observed good, respectful interaction between staff and people who used the service and with visitors. The atmosphere within the home was relaxed and friendly. We saw staff cared for people with dignity and respect and attended to their needs discreetly. We saw staff knocked and waited for an answer before entering bathrooms, toilets and bedrooms. This was to ensure people had their privacy and dignity respected. It was clear on observing interactions that staff knew people very well and there were friendly conversations happening all around the home.

All staff and one of the activity coordinators in particular had worked hard to be inclusive with a person who came from a different culture and background. They had accessed appropriate music and videos and used pictorial communication cards to help facilitate good communication.

The service produced a guide for people who may want to use their services and their families. This included information about the service and the facilities, the complaints procedure and the staffing structure of the home and their designations.

Relatives and residents meetings were held regularly and we saw minutes of these. Discussions included car parking, staffing, sickness, food, management arrangements, signage, activities, use of CCTV, sensor mats, laundry and paperwork. We saw that families were welcomed and could stay and enjoy a meal with their loved ones if they wished to.

Care records included advanced care plans where people's wishes and preferences around how they wanted to be cared for at the end of their lives were recorded.

Two senior staff had undertaken training and specialised in end of life care. Further end of life care training was planned so that people could spend their last days in a familiar environment, with people they knew

and trusted, if this was their wish.

Good

Is the service responsive?

Our findings

We saw people had furnished their rooms with their own personal belongings and mementoes brought with them from home. Some people spent most of their times in their rooms. One person said, "I have everything I need, I am very comfortable here".

Care files included a range of health and personal information. This included their preferred name and there was reference to people's choices with regard to care and treatment within the records. There was documentation around people's preferred rising and retiring times, whether they wanted to be checked on overnight, how they wanted their pillows and whether they were able to use a call bell.

Staff we observed had a good knowledge of people's preferences, likes and dislikes and demonstrated a good understanding of people's personalities. We saw that the service was committed to people having choice and this was clear when observing the mealtime. People were given plenty of time to make their choices and were comfortable to ask for alternatives

We saw that care plans had been reviewed on at least a monthly basis and updated with any changes to care delivery. Life stories were in the process of being completed by the activities coordinators. These would provide staff with an insight into each individual's background history, family structure and interests.

There were two activities coordinators employed at the home. One worked during the week and one at weekend, to help ensure activities were available to people at all times. We spoke with one of the coordinators who told us they had a programme of activities planned. However, they were flexible and always had alternatives to do if planned activities could not be undertaken or people did not want these.

We saw a number of activities offered including quizzes, aromatherapy, doll therapy, chair exercises, music, entertainers, gardening and one to one sessions. One to one could be something like a hand massage, a chat or reading to someone. This can be particularly beneficial in a home where some people are at risk of isolation due to having to or choosing to stay in their rooms for a significant amount of time. Families were welcome to join in with activities they wished.

The complaints procedure was displayed within the home and we saw the provider had a clear procedure in place with regard to responding to any complaints or concerns. People we spoke with told us they would feel able to raise concerns with the manager any of the staff.

We saw a number of compliment cards from relatives. Comments included, "Just wanted to say how happy I am with the changes at Four Oaks. The centre has changed a lot including a more positive environment with lovely staff and a positive atmosphere." Another card complimented staff for their kind and caring attitude.

Requires Improvement

Is the service well-led?

Our findings

The home had been open a relatively short time and the present manager was the third manager to be appointed. People told us they felt unsettled due to these changes. The new manager, who was in the process of registering with the CQC, had only been in the position for nine weeks, but had experience of managing other similar services. She was still in the process of implementing systems and processes and had made some improvements to the service.

One staff member told us, "This manager will do what she says. They do support you". A visiting health professional said, "The manager and deputy are always around and they do things there and then, very prompt".

We saw evidence of recent staff meetings. Issues discussed included uniform, CQC inspection, recruitment, training, sickness, kitchen, handover and maintenance. A range of policies and procedures were in place and were accessible for staff to refer to as required.

We saw maintenance checks for the service including fire equipment, gas and electrical, lift and hosts and small portable appliances had been undertaken and certificates were valid and in date.

There were systems in place to regularly assess and monitor the quality of the service. The home completed regular audits in a number of areas. Audits included care plans, medicines management, feedback from people who used the service and their relatives, housekeeping, health and safety and environmental safety. There was evidence of monthly hand hygiene audits. We also saw evidence of provider level auditing of the service as a whole.

Within care files we saw that, although the files had been reviewed regularly, these reviews had not picked up that records of issues requiring monitoring were inconsistent. Care file reviews needed to be more robust to ensure these inconsistencies were picked up and actions taken. Food and fluid charts were also not always completed appropriately. This was pointed out to the manager on the day of the inspection and actions taken immediately to address this.

We looked at how accidents and incidents were managed. Accidents and incidents were completed by staff within care records in a timely manner and CQC had been notified as required. They were also documented in a central log, which included details of the accident, the person it had happened to, any witnesses, actions, where reported to and the outcome. A similar log was kept for falls. Regular audits and analysis were carried out on accidents, incidents and falls to help identify any trends or patterns so that these could be addressed. We saw that actions taken were appropriate, such as referrals to the falls team, implementation of equipment or aids.

Staff competency assessments in the area of medication administration were undertaken and medication audits were completed regularly. Staff files were audited on a monthly basis to ensure they included the correct information.