Care Quality Commission

Acegold Limited

Oakfield Care Home

Inspection report

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

Overall summary

This inspection took place on 18 January 2016 and was unannounced. When the service was last inspected in February 2014 there were no breaches of the legal requirements identified.

Oakfield Care Home is registered to provide accommodation and nursing care for up to 28 people. At the time of our inspection there were 26 people living at the service.

There was a registered manager in post who was currently working their 3 months' notice. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The regional support manager told us that they are currently undertaking a recruitment drive to appoint a new manager.

The provider was not deploying sufficient numbers of staff to ensure they could meet people's care and treatment needs.

Summary of findings

Risk assessments relating to the health, safety and welfare of people were not effectively managed. Staff did not have appropriate guidance in place to mitigate potential risks to keep the person safe.

There were ineffective governance systems in place to monitor health and safety and the welfare of people.

The service was not consistently responsive to people's needs. The quality and content of care plans was variable. Although some were well written with clear guidance for staff to follow, this was not consistent. Care plans were not consistently written in conjunction with people or their representative and people had not signed their care plans to indicate their agreement.

People spoke positively about the staff. We observed that people were treated with kindness and compassion by the staff. Staff were not always aware of issues of confidentiality and at times did speak about people in front of other people.

A range of checks had been carried out on staff to determine their suitability for the work. Staff were supported through an adequate training and supervision programme. Staff we spoke with demonstrated a good understanding of how to recognise and report suspected abuse. Staff were supported through an effective training and supervision programme.

People's rights were being upheld in line with the Mental Capacity Act 2005. This is a legal framework to protect people who are unable to make certain decisions themselves. We saw information in people's support plans about mental capacity and Deprivation of Liberty Safeguards (DoLS). DoLS applications had been applied for appropriately. These safeguards aim to protect people living in care homes and hospitals from being inappropriately deprived of their liberty.

People had their physical and mental health needs monitored. All care records that we viewed showed people had access to healthcare professionals according to their specific needs.

Relatives were welcomed to the service and could visit people at times that were convenient to them. People maintained contact with their family and were therefore not isolated from those people closest to them. People were encouraged to provide feedback on their experience of the service.

We found four breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of this report.

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 not always safe.

There were not always sufficient numbers of staff to meet people's needs safely.

Risk assessments were not adequately assessed to mitigate the risks to the person.

Safe recruitment processes were in place that safeguarded people living in the home. A range of checks had been carried out on staff to determine their suitability for employment.

Medicines were managed safely.

Requires improvement

Is the service effective?
The service was not always effective.

People's nutrition and hydration needs were not always effectively managed.

People's rights were being upheld in line with the Mental Capacity Act 2005.

Staff monitored people's healthcare needs and made referrals to other healthcare professionals where appropriate.

Requires improvement

Is the service caring?
The service was not always caring.

Staff were not always aware of issues of confidentiality and at times did speak about people in front of other people.

People spoke positively about the staff and told us they were caring.

Staff were knowledgeable about people's needs and told us they aimed to provide personal, individual care to people.

Requires improvement

Is the service responsive?
The service was not always responsive.

Care plans were not consistently person centred.

Relatives were welcomed to the service and could visit people at times that were convenient to them.

The provider had systems in place to receive and monitor any complaints that were made.

Requires improvement

Is the service well-led?
The service was not well-led.

Requires improvement

Summary of findings

Regular staff meetings were held but some staff members did not feel listened to.

Systems were not being operated effectively to assess and monitor the quality and safety of the service provided.

People were encouraged to provide feedback on their experience of the service.

Oakfield 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 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 18 January 2016 and was unannounced. The inspection was undertaken by two inspectors.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

We reviewed the information we held about the service. This included previous inspection reports, statutory notifications (issues providers are legally required to notify us about) other enquiries from and about the provider and other key information we hold about the service.

We spoke with five people, four visitors and five members of staff. We also spoke with the deputy manager and the regional manager.

We reviewed the care plans and associated records of four people. We also reviewed a sample of the Medicines Administration Records (MAR) of some of the people who lived at the service. We also reviewed documents in relation to the quality and safety of the service, staff recruitment, training and supervision.

Requires improvement

Is the service safe?

Our findings

The provider was not deploying sufficient numbers of staff to ensure they could meet people's care and treatment needs. Staffing levels were assessed by following the Care Home Equation for Safe Staffing (CHESS) dependency tool. The tool determines the level of staffing required whilst taking into account the dependency needs of people. The dependency tool calculated that 4.3 staff should cover the AM shift, 3.6 staff should cover the PM shift and 2.2 staff should cover the overnight shift. We reviewed the staffing rotas for a three week period from 28 December 2015 to 17 January 2016. Staffing rotas demonstrated that staffing levels were not consistently maintained to the correct level. One member of staff told us; "Staffing levels are so low it's become the norm."

We observed that there did not appear to be enough staff on duty to ensure people's needs were met. People's bedrooms were located over three floors and it was not always easy to locate a member of staff. We overheard staff advising people they would be with them "soon" when they asked for assistance. We reviewed call bell response times over a two day period and they varied from 2.9 to 4.7 minutes. We were told by the regional support manager that a reasonable response time would be three minutes. One staff member said, "There isn't enough staff. Lunchtime is very difficult because so many people need help." Visitors said; "There aren't enough staff; they try but it's hard to recruit" and "They often seem short of staff." Another visitor said, "There aren't enough care staff or cleaning staff. I clean my relative's bathroom and I change the bed." On the day before our inspection, a domestic member of staff did not turn up for work. There was no contingency plan in place to cover this unexpected absence. This resulted in domestic waste bags being left in one of the bathrooms as there was inadequate number of staff to deal with domestic duties. Despite the concerns regarding staffing levels, visitors said they did feel their relatives were safe living at Oakfield.

This is a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Risk assessments relating to the health, safety and welfare of people were not effectively managed to mitigate potential risks to the person. Care plans contained risk assessments for aspects of care such as mobility, falls, choking and nutrition. Where risks had been identified, some of the plans gave clear guidance to staff on how to minimise the risks. For example, one person who had been assessed as a high risk of falls had a comprehensive care plan in place which informed staff how they should move the person safely. There was recorded detail of the type of hoist and size of sling to be used, including the ID number and where the equipment was stored in the person's bedroom. The plan had been reviewed monthly and staff had documented that although the person could still weight bear, they "hung onto staff" and should therefore always be hoisted to avoid harm or injury. However, this level of detail was not consistent. Another person had been assessed as being at high risk of choking on 15/12/2015. The care plan said "Consult SALT (Speech and Language therapist)" and informed staff to follow "clear guidelines in care plan". However, there was no documentation to indicate if the SALT team had been contacted for advice and the care plan did not inform staff how to avoid the person choking. The plan informed staff to "Be made aware of action to be taken in case of choking", but there was no detail within the plan of how they should do this despite it being recorded that the person liked to eat crisps. This meant that staff did not have appropriate guidance in place to mitigate potential risks to keep the person safe.

This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were ineffective governance systems in place to monitor health and safety and the welfare of people. Although audits were undertaken on fire safety records, legionella, water temperatures, maintenance of safety equipment, gas safety, boilers, call systems, portable appliance testing (PAT) and window restrictors some actions were not taken forward. Fire drills were overdue and required daily maintenance checks were not undertaken. This was largely due to a full-time maintenance person not being in post.

This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were generally cared for in a safe, clean and hygienic environment. Staff knew their responsibilities in relation to the prevention and control of infection. Personal protective equipment (PPE) such as gloves and aprons

Requires improvement

Is the service safe?

were readily available and we observed staff using it prior to assisting people with personal care. Hand gel dispensers were available throughout the home and were in working order. Apart from storing domestic waste in the downstairs bathroom we observed that the hallways, rooms, communal areas and shared facilities were clean. Each room had a scheduled daily clean and a monthly deep clean. We did note that there were odours in parts of the service which required addressing. The deputy manager agreed to action this issue.

In 2015 the kitchen had been awarded a five star food hygiene rating by the local authority. Daily and monthly cleaning schedules were completed and food was stored at the correct temperature.

Medicines were managed safely. The nurse administering the medicines knew people well, and demonstrated a good knowledge of the medicines people were receiving and the reasons why. They were patient with people and did not rush them when giving them their medicines. When one person had difficulty swallowing their tablets, the reason for not administering was recorded and they advised the person that they would ask the GP to review them later that day.

Medicine Administration Records (MAR) were all signed and up to date. There were photographs in place and the MAR charts contained details of people's allergies. Where people had been prescribed medicines on a PRN (as required) basis, there were protocols in place. There were topical medicine MAR charts in people's files for those requiring lotions and creams to be applied. The charts included body maps showing where the creams should be applied and the reasons why. Care staff had signed to indicate they had applied the creams as prescribed. All of these were completed in full.

There had been an external audit undertaken by Boots the Chemist on 15/05/2015. A recommendation had been put in place to monitor the medicine fridge temperatures and this had been actioned.

The provider made sure that all new staff were checked to make sure they were suitable to work at the service. These checks included seeking references from previous employers and obtaining information from the Disclosure and Barring Service (DBS). The DBS helps employers to make safer recruitment decisions by providing information about a person's criminal record and whether they were barred from working with vulnerable adults.

People told us they felt safe at the home and with the staff who supported them. They told us they could talk to any of the staff. Staff told us they had received training in how to recognise and report abuse. Staff spoken with had a clear understanding of what may constitute abuse and how to report it. All were confident that any concerns reported would be fully investigated and action would be taken to make sure people were safe.

Staff understood the term 'whistleblowing'. This is a process for staff to raise concerns confidentially about potential malpractice in the workplace. The provider had a policy in place to support people who wished to raise concerns in this way.

The provider had appropriate arrangements for reporting and reviewing incidents and accidents. The manager audited all incidents to identify any particular trends or lessons to be learnt. Records showed these were clearly audited and any actions were followed up. When people had fallen, this had been fully documented and actions arising had been documented. For example, one person who was diabetic had fallen and had been found unconscious. Staff had recorded the person's blood sugar as part of their immediate action and paramedic support had been sought. The diabetic nurse had been liaised with and a new insulin regime had been implemented in accordance with their advice.

Requires improvement

Is the service effective?

Our findings

People's nutrition and hydration needs were not effectively managed. People's nutritional needs had been assessed and where risks had been identified action plans were in place in some plans, but not all. Some plans provided clear guidance for staff on how to meet people's nutritional needs and specialist support was sought appropriately. Their preferences had been documented and there were Speech And Language Therapist (SALT) guidelines on display in some people's bedrooms to inform staff of required actions. Providing person specific guidelines was not consistent practice. The regional manager had identified this as an issue in a recent audit and has incorporated an action plan to take this issue forward by his next visit. Their next visit was scheduled for February 2016.

The provider had recently partnered with a new group to deliver the catering. Through this partnership the service has access to professional skills and systems that ensured the menus would be varied and nutritious. We received positive comments from people regarding the food and drink. We observed that people were offered choices of food and the staff had a good understanding of people's food likes and dislikes. Where one person did not like carrots they were not put on their plate when lunch was served. Where people requested different options of food and sauces their requests were accommodated by the staff.

The provider ensured that staff providing care had the competence and skills to do so. Staff were supported through an adequate training and supervision programme. Staff told us they had received regular supervisions. We reviewed staff records which demonstrated that regular staff supervisions had been conducted. This meant that staff received effective support on an on-going basis and development needs could be acted upon.

New staff undertook an induction and mandatory training programme before starting to care for people on their own. Staff told us about the training they had received; this covered a variety of subjects such as health and safety, safeguarding, moving and handling, food hygiene and infection control. The remaining induction training period was over 12 weeks and included training specific to the new staff member's role and to the people they would be supporting. A training plan was in place which (random gap) demonstrated that the necessary mandatory training had been completed by staff members. The home had a 97% compliance rate with its own mandatory E learning programme. A member of staff who wass currently being inducted felt they were well-supported by their colleagues and the training programme. They told us; "The senior staff are really great and we support each other. They are amazing and I feel I can say anything to them."

People's rights were being upheld in line with the Mental Capacity Act 2005 (MCA 2005). This is a legal framework to protect people who are unable to make certain decisions themselves. In people's support plans there was information about their mental capacity and Deprivation of Liberty Safeguards (DoLS) being applied for. These safeguards aim to protect people living in care homes and hospitals from being inappropriately deprived of their liberty. These safeguards can only be used when a person lacks the mental capacity to make certain decisions and there is no other way of supporting the person safely. The deputy manager confirmed that some DoLS applications had been made and they waiting for a response from the supervisory authority. The records viewed confirmed this position.

Staff demonstrated an understanding of the MCA and how to make sure people who did not have the mental capacity to make certain decisions for themselves had their legal rights protected. 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.

Staff understood that informed decision making and ability to consent was dependant on people's mental capacity. Plans we looked at contained mental capacity assessments for all aspects of people's care. One member of staff told us; "If someone can't make decisions we bring in appropriate people for meetings. I show people clothes and ask people if they would like personal care." We observed staff asking people prior to supporting them throughout the inspection. For example, staff were overheard asking people "Do you want to get up now?" and "Would you like to come to the dining room for lunch?"

People had their physical and mental health needs monitored. All care records that we viewed showed people

Requires improvement

Is the service effective?

had access to healthcare professionals according to their specific needs. We saw written entries made from visiting health professionals, such as the GP. Information of health professional visits were documented in the person's care plan and recorded in the handover notes.

Requires improvement

Is the service caring?

Our findings

Staff were not always aware of issues of confidentiality and at times did speak about people in front of other people. We observed one member of staff assisting someone to eat their lunch in their bedroom. Another staff member went into the person's bedroom and both staff members then discussed another member of staff in front of the person eating their lunch. At one point both members of staff left the person's bedroom to continue their discussion, which meant the person's lunch was interrupted. Although the staff in question were frustrated because they felt there were not enough staff available to assist with lunch, their actions demonstrated a lack of respect for the person. One relative said they regularly overheard staff discussing work and colleagues in the staff room which was located in the same corridor as some bedrooms. They said they had overheard, "A lot of discontent".

For the majority of the day we observed that people were treated with kindness and compassion by the staff. The nurse in particular knew people very well and demonstrated a level of commitment that was exceptional. They knew that one person liked a beer on occasions so they bought them a bottle of beer as a present. The nurse was well-liked and respected by people. Comments included; "This place is held together by [nurse's name]" and "I wouldn't want my relative to live anywhere else because of [nurse's name]". Other care staff we observed were caring and supporting people in a gentle and calm manner. All the people we spoke with thought the staff were very good and they felt well looked after. One visitor told us; "[person's name] is being looked after very well. It's my first visit here and it's been very welcoming and a positive experience."

All the staff we spoke with demonstrated passion and commitment towards their role and the people they were caring for. One member of staff told us, "We've got a brilliant team but we have been stretched. People can bring their own things as it's their home at the end of the day. I'm happy here." To enable people to go out one member of staff took their driving test so they could use the Bath Community Transport minibus. This enabled people to visit the theatre and local school where the service had established a close relationship. They told us; "I have the best interests of the residents needs at heart."

When staff discussed people's care needs with us it was clear they knew people well and understood the support they needed. One member of staff told us about certain people who liked having their hair and nails done "so they feel special about themselves." They spoke of people in a respectful and kind way. People's privacy was respected and all personal care was provided in private. Personal care was carried out behind closed doors, and we observed staff knocking before they entered. One member of staff told us, "I always knock on the boor before entering and introduce myself. I make sure the door is shut when providing personal care and put a towel over them."

Requires improvement

Is the service responsive?

Our findings

The service was not consistently responsive to people's needs. The quality and content of care plans was variable. Although some were well written, with clear guidance for staff to follow, this was not consistent. Care plans were not consistently written in conjunction with people or their representative and people had not signed their care plans to indicate their agreement. Two of the relatives we spoke with confirmed they had been invited to attend care plan reviews, but another visitor said they had not been asked to be involved. This meant that care plans might not always reflect the ways in which people wanted to receive their care.

Some plans had been reviewed monthly, others were not. For example, one plan gave staff clear guidance on how to care for someone with complex communication needs. The detail was person centred and gave staff examples of how they could ensure they were understood and that they understood the person. However, in the same person's plan we also noted a lack of information in relation to some of the person's other needs. For example, it was documented that the person experienced shortness of breath. The care plan informed staff the person had been prescribed inhalers and "Not to go for long walks". There was no other information in relation to how staff should support the person.

In another person's plan it was documented "Will need help as they get muddled at times". This was in relation to the person's cognitive state, but there was no information documented for care staff on how they should help the person. The same person's plan informed staff the person had a catheter in situ, but there was no catheter care plan in place despite the person experiencing frequent urinary tract infections in the past. This potentially meant that people might not have their needs fully met because the information within some of the care plans was not sufficiently detailed. A recent care plan audit conducted by the regional manager also identified similar issues. They made comments which they required staff members to take forward by the time of their scheduled next visit in February 2016. An example of this included that a falls risk assessment had not been completed in full and the care plan did not identify risk management measures or any moving and handling procedures.

People who were at risk of developing pressure sores had pressure relieving equipment in place, such as air mattresses. However, there was nothing documented within the care plans or on the position change charts within people's bedrooms to indicate the correct mattress setting. We asked three members of staff how they knew the required mattress setting for one person, and two gave different answers and one said they didn't know. The person's mattress was set at eight, but did not feel properly inflated. We showed this to the three staff members and action was taken to check the setting and to ensure it was correctly inflated. Staff were also unable to state the required mattress setting for another person. Although position change charts were in place and were up to date, the charts did not state the required frequency of position change or the required mattress setting. The paperwork in place did have sections for this information to be documented but they had been left blank. The lack of information available for staff could impact on the quality of care. One relative said; "I am not convinced that staff are always aware of people's needs".

Care plans were not consistently person centred. Life stories were not always completed which meant that staff did not always have an understanding of people's lives before they moved to the service.

This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

A dedicated activities coordinator was employed by the service and they told us; "I'm here to make the residents happier." Staff members and people praised their contribution. One staff member thought they were "one of the best activities coordinators." One person commented; "I like the activities. They're always thinking of lots of things to do". On the day of our inspection it was national Winnie the Pooh Day and the activities coordinator arranged one-to-one time and group activities following the theme of the day. People really enjoyed the theme as it reminded them of their childhood. As well as a structured weekly activities programme the service had links with a local school and pupils come to visit the service and people recently went to the school to watch the nativity play. The coordinator has also arranged World War II projects and trips to the ballet. One person did tell us; "I get involved with some of the activities, but not all. They're quite female orientated."

Requires improvement

Is the service responsive?

Relatives were welcomed to the service and could visit people at times that were convenient to them. People maintained contact with their family and were therefore not isolated from those people closest to them.

The provider had systems in place to receive and monitor any complaints that were made. We reviewed the complaints file. Where issues of concern were identified they were taken forward and actioned. People said they knew how to complain.

Requires improvement

Is the service well-led?

Our findings

Staff felt well-supported by the deputy manager and considered them to be the first point of contact. We received mixed comments from staff members regarding the recently resigned registered manager. Although regular staff meetings were held some staff members did not feel listened to. Comments included; "I have mentioned staffing levels to the registered manager." and "If someone went off sick we would call on existing staff. If there are no staff available we would work below the staffing level." The regional manager recently reported that the home has not recruited to their expected level. Their recruitment target is full staffing hours plus 20% to cover for sickness and annual leave.

The service had a number of internal systems used to monitor quality on a regular basis such as meetings held daily with heads of departments to communicate current concerns and action required. To ensure people's care needs were met, the manager conducted monthly audits on nutrition, admission, resident of the day, falls, safeguarding, medication, mental capacity and pressure ulcers. Despite the audits being undertaken by the manager they did not identify the variable quality of the care plans.

Not having access to a full-time maintenance man was also affecting the level of service provided. The upstairs bathroom was out of operation. Several of the electronic door stops had faulty batteries which needed replacing. The door stops alarmed continuously and staff said they had been waiting for them to be fixed "for a month". One visitor was hanging curtains in their relative's room because there was nobody else available to do this.

The regional manager visited the home regularly and compiled a monthly visit report. The visits were used as an opportunity for the regional manager and manager to discuss issues related to the quality of the service and welfare of people that used the service. Clear action plans were evident and timescales given to areas in need of attention. Actions from previous monthly visits were reviewed to ensure appropriate actions had been forward within the required timescales. The issues identified by the regional manager reflected our inspections findings and have been noted in their audit as action items, such as the inconsistency of quality of the care plans and the need for further recruitment.

Residents who were particularly vulnerable due to their current needs were monitored by the senior team and actions were recorded in relation to any concerns raised. The home had introduced a 'resident of the day' system which focused on a particular person on a rotational basis. The family of the person received an invite to attend the home to speak in person about their family member. The care plan was audited, their room had a deep clean and the resident had time to speak with key departmental heads such as the manager, the chef, housekeeping and maintenance to ensure the service is sufficiently meeting their needs. This demonstrated that the service was introducing measures to view care and adapting to change.

People were encouraged to provide feedback on their experience of the service to monitor the quality of service provided. Regular resident and relatives meetings were held to seek people's views. The meetings also provided an opportunity for the manager to provide an update on issues affecting the service and their proposed actions. Annual customer surveys were conducted with people and their relatives or representatives. Plans were in place which demonstrated how the service was responding to the issues raised. Overall positive feedback was received about the leadership from people and their relatives.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing **The provider was not deploying sufficient numbers of staff to ensure they could meet people's care and treatment needs.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **Risk assessments relating to the health, safety and welfare of people were not effectively managed to mitigate potential risks to the person.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **There were ineffective governance systems in place to monitor health and safety and the welfare of people.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care **Care plans were not consistently person centred. This meant that care plans might not always reflect the ways in which people wanted to receive their care.**