Oriel Healthcare Limited

# Oriel Care Home

## Inspection report

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## Ratings

| | |
|---|---|
| Overall rating for this service | Requires Improvement |

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

# Summary of findings

## Overall summary

This unannounced comprehensive inspection took place at the Oriel Care Home on 4th December 2018. Phone calls were undertaken to people with experience of the service on 5th and 17th December 2018.

Oriel Care Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. The care quality commission, (CQC), regulates both the premises and the care provided, and both were looked at during this inspection.

Oriel care home accommodates 33 people and has adapted facilities. There were 28 people living at the home, at the time of this inspection. The service has a registered manager, who was present during our inspection. A registered manager is a person who has registered with the CQC 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.

This was the first inspection and rating of this service, since it was taken over by a new provider in January 2018.

The service has been rated as requires improvement.

We found areas of service provision where the provider was in breach of regulations. The providers systems for governance were not effective in identifying and addressing risks to people and needed improvement. We found that care was not always delivered safely. You can see what action we told the provider to take at the back of the full version of this report.

Risk assessments were in place for each person. These did not effectively identify, assess or mitigate risks to people, to ensure effective safe care. People had suffered multiple falls, in some cases resulting in serious injury. The registered manager did not recognise or consider the potential for raising safe guarding concerns or following the duty of candour regulations, regarding these serious injuries.

Staff were recruited safely and new staff completed induction training. There was a training plan in place for all mandatory safety training. Staff had received training in how to safeguard people from abuse. Staff received supervision and attended staff meetings on a regular basis. We found that issues raised by staff were not always effectively dealt with, this meant that safeguarding was not as effective as it could have been.

We found that the safe evacuation of the home was compromised. Emergency evacuation routes were found to be blocked and one emergency exit door was found securely bolted. We spoke with the provider about this, who took immediate action to remove bolts from doors and to remove obstructions from the evacuation routes. We also informed the West Midlands Fire Service, who undertook an inspection of the

home.

We saw medication being safely administered, however we found medications were not safely stored. During this inspection we found that storage temperatures were too high, which could make medication less effective or unsafe. We also found some medications were left unsupervised, this is an unsafe practice and poses a risk to people in the home.

People told us they were happy with the care they received. Staff used support plans to ensure people were effectively cared for. Support plans were regularly reviewed and updated. We noticed that where accidents had taken place, these were detailed in support plans as an event, however preventative strategies were not recorded. People told us that the staff were caring, compassionate, attentive to their needs, patient, very nice, very good, pleasant, and helpful. During our observations we saw people sitting, in silence, for long periods of time without any interaction or meaningful activity.

People were supported to have enough to eat and drink. People told us they enjoyed their meals. Meals were well presented and nutritious. People were not provided with snacks and refreshments to help themselves to during the day or evening although snacks refreshments were available if requested. The Hagley dining area provided a poor environment, with some people isolated from the general meal time experience, with their backs to the main area and facing the wall.

There was a lack of direction signage making it difficult for people to navigate around the home independently. Communal seating areas did not enable people to chat with each other. People spent long periods of time in silence and asleep and peoples comfort needs, such as foot stools, were not always considered.

The registered manager was not using a dependency tool to determine staffing levels. We have concerns over the staffing levels at night. We found that there was not enough staff to answer people's alarm calls in a prompt way. We found that night staff helped people out of bed in the morning. Staff told us that due to the number of staff available, some people were assisted to wash and dress as early as 5am.

There was an ongoing programme of activities within the home. Local school children had visited people. People and school children were writing to each other. Some people attended local functions. Some people told us they felt bored during the day. It was the providers policy that the televisions were not in use in the communal areas until the evening.

The providers governance system and processes, to monitor the quality of care and the safety of the premises, were not effective. Audits had not identified areas for improvement, even when these were clearly known to the registered manager. The registered manager did not always respond to those raising concerns about the service. When people experienced serious injuries, the provider and registered manager were not fully undertaking their duty of candour responsibilities.

## 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.

Where risks were assessed, assessments were not always effective and did not adequately reduce or mitigate risks.

There was no overview of accidents and incidents for lessons learnt.

Medication was not stored consistently safely.

There was not consistently sufficient staff to meet peoples needs

### Is the service effective?

**Good**

The service was effective.

The staff had access to regular training to ensure they could support people effectively.

People had sufficient amounts to eat and drink.

People were supported to access healthcare services when this was required.

There was a lack of navigational signage, impacting upon people's ability to orientate themselves or move around their home independently.

### Is the service caring?

**Requires Improvement**

The service was not consistently caring.

People were not consistently supported by staff that demonstrated they were considerate and respected people's dignity.

People's social and comfort needs were not consistently supported.

Seating in communal lounge areas was not positioned to enable people to chat to each other.

## Is the service responsive?

Requires Improvement

The service was not always responsive.

People were assisted to get up very early, at times that suited staffing levels.

Complaints were not always responded to effectively. Residents were reluctant to raise issues as they considered the staff were too busy and relatives did not consistently feel listened to.

The registered manager did not follow the service's complaints procedure.

The activities coordinator was reviewing people's individual preferences and choices for activities.

## Is the service well-led?

Requires Improvement

The service was not well led.

The provider's systems and processes to monitor the quality of care and the safety of premises, was not effective.

The registered manager's audits did not identify areas for improvement, even when these were known to the registered manager.

The provider did not have a system to assist them to decide dependency levels of people or the number of staff required to effectively and safely care for them.

The provider and registered manager were not practicing a duty of candour in the appropriate circumstances.

# Oriel 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 4th December 2018 and was unannounced. The inspection was undertaken by one inspector and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert-by experience's area of expertise was, dementia and older people who use regulated services.

Before the inspection we reviewed other information, we held about the service. Providers are required by law to notify us about events and incidents that occur, we refer to these as `notifications`. We looked at notifications the provider had sent to us. We also contacted the local authority who monitor and commission services, for the information they held about the service. We used the information we had gathered to plan what areas we were going to focus on during the inspection.

During this inspection we sought the views of eight people. Some people living at the home were not able to clearly express their views. We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk to us. We also spoke with seven relatives and nine staff. We received feedback on the service from the local authority commissioning team and a member of the community dietitian team. We sampled records, including six support plans, four staff recruitment records, accident and incident records, various feedback information including complaints, quality assurance records, risk management overviews and building safety records.

Requires Improvement

# Is the service safe?

## Our findings

At this inspection we found there were areas where the provider needed to improve the service and the rating for this key question is `Requires improvement`

We heard from people, their relatives, and staff of a history of repeated falls. We viewed the accident and incident records. Twelve falls were recorded in October 2018, one person had experienced four unwitnessed falls in one day. People had experienced serious injuries from falls, including broken bones, which had impacted on their mobility and independence. Accident report forms were not fully completed and did not record future preventative action. We found that whilst accidents leading to serious injuries were recorded within the support plan, risk assessment information and expected preventative actions were not reflected in support plan updates. The provider did not ensure that accidents and incidents were reviewed and lessons learnt and peoples risk of falls reduced. We found that assistive technology was in use, for example sensor mats used to identify people that may have fallen, or may be at risk when getting out of bed during the night.

People did not consistently have their risks identified and mitigated. For example, staff told us they had not been provided with information on behaviour that challenged and as a consequence a person had been at risk of harm. Another person did not have sufficient guidance and systems in place to mobilise them safely. This meant that staff sometimes were unable to support them out of bed consistently in a safe way. We spoke with the provider and they took immediate steps to rectify.

People and staff told us that when they were activating their emergency buzzers at night, they did not always get a timely response. This was due to a combination of people's increased dependencies and three staff available to respond at night.

Staff told us that staffing levels were impacting on their ability to effectively meet the needs of people. We looked at the staff rota and found that between 10pm and 7am there were three staff on duty, two in the Ibstock area and one in the Hagley area. Some people required assistance from two staff, leaving just one for the remainder of the home. Staff explained the night time duties, we were told, "We do hourly or two hourly checks through the night, we respond to buzzers and take people to the toilet, we prepare snacks if they need them, we do the washing and the ironing, clean the kitchens and communal areas, clean the bathrooms and toilets, prepare vegetables for the following days meal, peeling and putting into pots, it's hard work we have people with challenging behaviour wandering around. We have asked for extra staff and have been told no".

The Registered Manager stated that there was not a dependency tool in place. We discussed this with the provider, who implemented a dependency tool, following this inspection and increased staffing levels at night.

Staff had received training in Safeguarding, and staff spoken to were aware of their responsibilities. Staff told us the Registered Manager did not always respond appropriately to concerns raised by staff, to ensure

the safety of persons living in the home. This meant that safeguarding was not always effective. Staff were knowledgeable about the whistle blowing policy but had failed to use it.

We found emergency escape doors to be secured by bolts top and bottom. We also found escape routes to be obstructed by delivery boxes and drying laundry. Escape route signage was intermittent. Staff did not understand how the emergency exit doors were secured or how to open them. During this inspection the provider and registered manager immediately rectified these issues and arranged training for staff. The West Midlands Fire Service are aware of these circumstances and have visited the premises since this inspection.

We found that the service's medication policy was not always being followed. We found medication storage was not safe. Medication was not always stored in secure locations, medication was found unsupervised in a communal office area. At this inspection the provider agreed to review medication storage and since this inspection has acted to reduce temperatures and improve the medication storage facilities. Staff administering medication were clearly identifiable, wearing red tabards clearly informing others that they are not to be disturbed. This helps to minimise the risk of medication errors.

Staff were seen to be wearing personal protective equipment such as disposable gloves and aprons. We noted that only large gloves were available for staff to use. Badly fitting gloves could lead to poor infection control. The provider agreed to order a full range of sizes.

We received mixed comments from people about feeling safe when supported by staff. People told us, "Yes I feel safe", and, "I'm well looked after and yes I do feel safe". One person told us "I was given the wrong medication, they told me what happened and they were very upset and apologetic".

Staff told us that prior to commencing in post, recruitment checks were carried out and references sought. We sampled two recruitment files and found this to be the case.

Good

# Is the service effective?

## Our findings

People told us they were happy with the care they received. One relative said, "They are unfailing, kind and thoughtful". People had support plans that were used by staff to determine how to meet the needs of individual people. As part of this inspection we sampled six support plans. There was a pre- assessment and support planning process to capture the needs of people and how they would be met in a person-centred way. We found that support plans were updated monthly and again if there were any changes in the needs of the person. Some relatives said that they were invited to the support plan review and notified of any changes. Others said that they were not. One relative told us they were, "On the whole I'm quite impressed, we have a special mattress and a reclining chair".

New staff received Induction training and there was a training plan to set out the training for the year. Staff felt they had the knowledge to support people effectively. Staff told us they had regular supervision and staff meetings.

One person told us, "The food is good. We have a choice of two things at dinner time and can have a full breakfast". Another person told us, "The food is quite nice, not much choice but it's good". We heard a member of staff explaining the food options for lunch. The person said that they didn't want what was on offer. The staff member asked the person what they would like, they asked for an omelette, the member of staff agreed to organise this. Another person told us that they were on a special diet and they were happy with what they were given to eat and drink. Another person told us, "There isn't anything I dislike, the food is reasonable. I was a good cook. They do try to give you food that you like. They always ask you what you like and you have a choice". We found that where people were on a special diet staff were aware of this and the information was available in the kitchen.

There were not any snacks or drinks available for people to access independently, between meals or in the evening. Staff told us that if a person asked for anything extra to eat or drink, they would arrange this.

We noted that the layout of the building and the lack of directional or door signage such as the lounges, toilets and bedrooms, made it difficult for people to navigate around their home independently, or to check where they were. The provider agreed to look at the provision of suitable signage throughout the home.

We found that the home had links with external health care professionals, such as the district nursing service and dieticians. The Dietitian Service told us they had completed some training for the staff, at the care home, in October 2017. Training included nutrition screening, use of the recording tools and local guidelines for management of malnutrition. They told us they have no major concerns about the home, that staff have a positive attitude and engage well with their department. They said that all recent referrals for dietitian input have been appropriate. Information about visits from external health care professionals were recorded in individual support plans.

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. We found the service was working within the principles of the MCA. The registered manager had completed capacity assessments for people, when these were needed. Where deprivation of liberty, (DOL's), were in place, these had been notified to the care quality commission.

People can only be deprived of their liberty to receive care and treatment with appropriate legal authority. We checked whether the service was working within the principles of the MCA. We heard from people using the service, their relatives and staff, that consent was obtained and recorded within the persons support plan as part of the support planning process.

Requires Improvement

# Is the service caring?

## Our findings

At this inspection we found there were areas where the provider needed to improve the service and the rating for this key question is `Requires improvement`

People were not consistently treated in a kind way. For example, we saw one person, who appeared to be distressed and in a compromised situation. We alerted a member of staff to this situation who told us the person was having a "meltdown" and they were not going to disturb them as they didn't want to increase their distress, however the person needed support to maintain their dignity. We spoke with the provider and they said they would investigate this situation and ensure the person was safe.

Staff did not always prioritise people's social needs. For example, a member of staff walked into the lounge but did not talk to the two people that were awake, instead they went over to the other member of staff and chatted. A third staff member came into the room with a wheelchair, they woke a sleeping person and said, "We need to go to your room to see the District Nurse". The person appeared confused and the staff member appeared kind and reassuring, explaining again what needed to happen. Having woken the person, they left the wheelchair in front of them and went off to join in the conversation with two other members of staff. The person went back to sleep. The priorities of the staff had taken priority over the needs of this person.

People's comfort needs were not always considered, we noticed that foot stools were available but not in use and some people looked uncomfortable with their legs stretched out in front of them. Staff later told us that some people should be sitting with their feet elevated and this was recorded in their support plans. When the lounge music stopped staff did not respond to this and people were sleeping in silence with just the hoover and ringing phones for back ground noise.

People did not consistently enjoy their meal time experience. One relative said "the dining room is cramped". We saw that one of the dining rooms was very cramped and some people were sitting at a table pushed against the wall, and ate their meals facing the wall. This detracted from the overall meal time experience and limited the opportunity for social interaction.

We saw that the way the chairs were positioned in the lounge, around the walls with everyone sitting with their back to a wall, did not enable people to engage in conversation with those around them, it was difficult for them to see who was next to them, and those they could see across the room were too far away to talk with. We saw that people were mainly sleeping in silence. We brought this to the attention of the provider who agreed to review the seating arrangements.

There were mixed views between people, their relatives and staff regarding how people's privacy, dignity and independence was promoted. For example, one relative told us "They put her on the toilet and didn't give her he buzzer, she was left there for over half an hour". Another person told us, "They are very good, they are caring. They are people oriented." Other people we spoke with told us staff were caring and compassionate. They said, "The staff are very attentive to people's needs. On the whole I am very pleased",

"It's different to what I thought it would be. They're a nice set of girls. It's one of the best things I've done; I have a laugh with the girls, they are very nice, very patient", "They are very good. They try their hardest. They are very pleasant and helpful, but they are busy because there is a lot of people to help. They do very well for all the people", "They are very good, they are caring, they are people orientated", "The care is excellent, I don't have a real criticism at all", "The staff are very pleasant" and "The staff are very good, I don't have any complaints. I couldn't manage at home".

One relative described the staff as very caring, they said, "They look after us too, they'll sit down and ask how I am and offer a cup of tea". They also described a bond between support workers, saying, "They are supportive of one another". They described how supportive staff had been and the level of reassurance they had received from staff, when considering if to go on holiday, leaving their relative in the care of the home.

The Registered Manager informed us that no one was using advocacy services. They told us that if advocacy services were needed they would arrange them. We did not see evidence of people being involved in decisions about their day to day activities.

Requires Improvement

# Is the service responsive?

## Our findings

At this inspection we found there were areas where the provider needed to improve the service and the rating for this key question is `Requires Improvement`

People did not always receive care at the time they wanted support. For example, one staff member told us, "In the morning we have to do all of the hard ones before the day staff come in, we have to get people up at 5.30am and 6am, it's not right". Staff also told us that people did not want to get up at this time and they had raised this issue, at the night staff meeting, the registered manager had told them, "keep encouraging them until they do". One relative told us, "Getting up early is a bone of contention". People were not consistently supported in a person-centred way.

The service had a complaints policy and procedure, we saw these were not always being followed. Two complaints had been received, but there was a lack of evidence that they had been investigated or concluded. No recent complaints or concerns were recorded. We found that people were reluctant to raise concerns, one told us "I didn't want to bother anyone" and another said, "They were so busy I didn't want to interrupt them". We spoke to a relative who had raised a verbal concern but had not had any response or outcome. We discussed this with the provider who is reviewing how complaints are raised and dealt with.

We found that staff had a good knowledge of people, their needs and what was in the support plans. We saw that people and their relatives were involved in planning of their support. We could see that there was personalised information setting out medical conditions and how these impacted on care delivery and information to keep people safe. We sampled support plan review information and could see that support plans were updated, if a significant event or change, and at least once per year. Relatives were not consistently given the opportunity to attend service reviews. We heard from some relatives that if they were not able to attend they always got a copy to sign and send back. Some relatives also told us that they could contribute to reviews, by phone, and others told us they were not invited to the review process.

One person was reading a newspaper and told us "it is delivered every day". Children from the local primary school had visited the home the day before. One person told us, "Children came in from the school yesterday, it was lovely to see them, and I think they are coming back after Christmas." One person told us they preferred to stay in their room, they said "I know there's a lounge, but with everyone asleep I can't stand it". Another person said, "What dreary music, it's a bit dull." Another person said, "I don't go out and there isn't really anything to do during the day. I don't watch television but they do have competitions and music".

There was an activities coordinator in the home. The activities coordinator was in the process of meeting with people to review their preferences and choices for activities. They also told us that they were sharing best practice ideas with other care homes in the group. They told us there is a variety of group activities and one to one activities. They explained that they are trying to bring the community into the home and were working in partnership with the local school. They had set up a pen pal system between people and the children which they thought was working well.

We observed people, sitting in a lounge, be told that it was time for a Christmas quiz. People did not appear to know that the quiz was due to take place. One person who was enjoying a conversation, had stopped as it was too difficult to hear over the quiz. It was unclear if the activity had been agreed with people beforehand and not all people wanted to take part. The notice board had information about when and where activities would take place, but this was out of date, only covering up to the previous weekend.

People were supported to actively follow their religious beliefs. In the afternoon we observed four people being helped to get their coats on to go out. A volunteer was helping them, they told us that they were going to a Church Christmas service, they were waiting for lifts to arrive as they no longer had a mini bus. The provider informed us that Taxis are used for those wanting to go out.

The provider had asked people's relatives to give feedback on the service on a public `health and social care review site` on the internet. Six relatives had done so. These reviews were all completed on 12th and 13th of June 2018 via a `review card`. These reviews detailed satisfaction with the home and the service received. The questions were generalised and did not enable the provider to seek feedback on areas relating to Oriel care home. Ten people took part in an `Oriel Home feedback survey` in May 2018. People raised issues and the registered manager responded. Where comments were made about food, the comments had been passed to the cook and no further outcome is recorded.

Requires Improvement

# Is the service well-led?

## Our findings

At this inspection we found there were areas where the provider needed to improve the service and the rating for this key question is `Requires improvement`

The provider did not have systems in place to ensure people received quality care. For example, the provider did not ensure that accidents and incidents were reviewed and lessons learnt and people's risk of falls reduced. We found people had multiple falls and there was no consistent overview to look at lessons learnt to reduce the risk. We spoke to one relative who told us they raised the concerns about the side effects of medicines their family member was taking. The staff then took action to have medicines reviewed but there was no consistent falls prevention system or over view in place. There was not an analysis of the falls information, identification of the poor quality of the completion of accident report forms or a falls prevention strategy.
Quality assurance systems failed to identify that people's risks were not identified and mitigated, and guidance provided for staff. For example, staff had not received guidance about one person who had behaviours that challenged about how to mitigate this risk. Another person did not want to be supported in a safe way. The registered manager had failed to respond to this risk to ensure the person and staff were safe.

The provider failed to have systems that identified where improvements were needed. For example, the infection control information included the statement that `Gloves available throughout the home`. This check had not found that a full range of glove sizes were not available, and that this could affect standards of infection control.

The medication audit had not identified the high storage temperatures, that had been evident for many months, the lack of space to store medication returns or the lack of security of medication. The registered manager was aware that the emergency escape doors were bolted but this was not evidenced within the record of `tests and inspections`.

The registered manager had not responded to concerns raised by staff and relatives about the lack of night staff support. Staff told us that they did not feel listened to and concerns raised were not consistently acted upon. One staff member, when asked if she had raised her concerns with the manager, said, "you can talk till you are blue in the face, we are short staffed".

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014, Good governance. The provider has failed to operate effective systems processes to ensure compliance with good Governance.

The provider and registered manager were not exercising a Duty of Candour, following incidents and accidents resulting in serious injuries. Since this inspection the provider has assessed all recent incidents and accidents resulting in serious injuries, against the Duty of Candour criteria and taken appropriate action.

A new provider took over in January 2018. Relatives spoke positively about the change in provider. One relative told us, "I am glad he has taken over". We received a mixed view from staff regarding the communication systems within the service.

The provider had an action plan in place to improve the environment and areas of the home had been redecorated. Staff spoken with were aware of the whistleblowing policy, but had failed to activate this to raise the safety concerns that they had.

This section is primarily information for the provider

# Action we have told the provider to take

The table below shows where regulations 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 will check that this action is taken by the provider.

| Regulated activity | Regulation |
| --- | --- |
| Accommodation for persons who require nursing or personal care | Regulation 17 HSCA RA Regulations 2014 Good governance<br><br>People who use services and others were not protected against the risks associated with the lack of effective systems and processes to identify and assess risks to the health, safety and welfare of people who use the service. |