Three Oaks Care Home Limited

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Inspection report

14 Gwynfa Close
Welwyn garden City
Herts AL6 0PR
Tel:01438 712939

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Ratings

Overall rating for this service	Inadequate
Is the service safe?	Inadequate
Is the service effective?	Requires Improvement
Is the service caring?	Requires Improvement
Is the service responsive?	Requires Improvement
Is the service well-led?	Inadequate

Overall summary

This inspection was undertaken on 17 February 2015 and was unannounced. Our previous inspection was undertaken on 01 August 2014 during which we identified breaches in relation to Regulations 10, 13 and 23. We found that some improvements had been made in all areas however, some issues relating to Regulations 13 and 23 remained unresolved at the time of this inspection.

Three Oaks Care Home Limited provides accommodation and personal care for up to 16 people with learning disabilities who may also have complex associated needs. At the time of our inspection 16 people used the service but two people were temporarily away from the home.

The service had experienced a period of instability in the management team which has had a negative impact on the quality of the service provided. The registered manager left the post in September 2014. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like

Summary of findings

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. We found that there was an acting manager in post who was working towards gaining the skills and qualifications to manage the service and become registered.

The Care Quality Commission (CQC) is required to monitor the operation of the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS) and to report on what we find. DoLS are put in place to protect people where they do not have capacity to make decisions and where it is considered necessary to restrict their freedom in some way, usually to protect themselves or others. At the time of the inspection applications had been made to the local authority in relation to people who lived at the service. Staff members had not received training in this area and were not familiar with their role in relation to MCA and DoLs.

The administration of medicines did not always promote the safety and well-being of people who used the service. Healthcare professionals were contacted if people needed additional support and all people who used the service had recently had all areas of their physical and mental health reviewed. However, people's care plans were not up to date and did not accurately reflect their needs.

There were insufficient numbers of staff employed to meet the needs of people in the home. A recruitment drive was underway and the manager described a safe recruitment processes. However, the established staff team had not all been recruited under safe procedures. Some training had been provided to give staff the skills and knowledge required to undertake their roles however, this did not cover all the basic core areas necessary to promote people's safety and well-being.

People's confidential information and medical histories were not always stored in a manner that promoted confidentiality. We saw many examples of kind and caring interaction between people and the staff team however, we also noted some examples where staff behaviours did not respect people's dignity. People received a balanced diet and appropriate support to eat however; they were not supported to make meaningful choices around the food provision.

The provider did not assess the quality of the service provided or monitor and manage risks to people's health, safety and welfare.

At this inspection we found the service to be in breach of Regulations 10,13, 14, 17, 22 and 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. These correspond to regulations 10, 12, 14, 17 and 18 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 the 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 is not safe.

Staff had not been recruited safely.

There were not always enough staff to provide the support people needed.

Staff knew how to recognise and report abuse.

Inadequate

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

Staff had not received the training necessary to meet the needs of people who lived in the home.

People received the support they needed to see their doctor. Where people had complex health care needs, appropriate specialist health care services were included in planning and providing their care.

People received enough to eat and received the support they needed to eat their meal.

Staff members were not familiar with their role and responsibilities in relation to the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS).

Requires Improvement

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

We saw that most staff members were caring and that people were treated in a kind and compassionate way. However, we saw examples where staff did not respect people's dignity.

Staff were knowledgeable about the support people required and about how they wanted their care to be provided.

Requires Improvement

Is the service responsive?
Some aspects of the service were not responsive.

Relatives were involved with people's care planning and review however; plans of care were not always put in place.

The provision of activity and stimulation did not always meet people's needs.

The provider had arrangements in place to support people and their relatives to raise issues of concern and provide feedback.

Requires Improvement

Is the service well-led?
The service is not always well-led.

Inadequate

Summary of findings

Staff spoke positively about the new manager at the home and said they were supportive of them.

The provider had not taken steps to identify and reduce the risks of inappropriate or unsafe care and support. The provider had not taken the steps to ensure people received a good quality of service.

People who lived in the home and their relatives were not asked for their opinions of the service.

Three Oaks Care Home Limited

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 met 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 under the Care Act 2014.

This inspection took place on 17 February 2015 and was unannounced. The inspection team was formed of two inspectors.

Before our inspection we reviewed information we held about the service including statutory notifications that had been submitted. Statutory notifications include information about important events which the provider is required to send us by law.

During the inspection we observed staff support people who used the service, we spoke with four support workers, the manager and the deputy manager. We also 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. People who lived at the home where unable to express their views. Subsequent to the inspection visit we spoke with family members to obtain their feedback on how people were supported to live their lives and we received feedback from health care professionals and the local authority commissioning team.

Inadequate

Is the service safe?

Our findings

At our previous inspection in August 2014 we identified a breach of regulation in relation to the management of medicines. At this inspection we found that there were still some issues in relation to the way people's medicines were managed. We were told by the manager that concerns had been identified by external professionals around medicines management in the home. They told us that they had received support with controlled drugs management as a result of this external input and that professionals were to return to conduct a full audit of medications the day after this inspection. We spoke to the external professionals following the inspection and they told us that they identified staff members' training on medication management needed to be reviewed as a matter of urgency.

We observed the lunchtime medication administration and noted that the drugs trolley remained in the medication room. People's medication was dispensed by a senior support worker and another staff member took the medication to people and supported them to take it. The senior signed to indicate that the medication had been given as prescribed. This did not represent good practice because the Medication Administration Record (MAR) should be signed by the person who administers the medication. This was discussed with the manager who was aware that this practice was not acceptable and told us that it would be addressed for the evening medication round. We found that the recorded balance of some medication did not tally with the stock held at the home. This meant that the people may not have received their medication as prescribed.

People's medicines were stored within a safe temperature range and controlled drugs were stored and managed securely. Prior to this inspection we had been advised of safety concerns around the administration of medication for people who lived with epilepsy. During the inspection we found that individual protocols for epilepsy medication had been developed and put in place with specialist professional and GP involvement. This showed that when concerns were raised the manager took effective action to promote people's safety in relation to medication management.

We found that the registered person had not protected people against the risk of unsafe medication administration. This was a continued breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 12(f)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Relatives said that they were concerned about the staffing levels in the home because people did not receive the stimulation and engagement they required and one to one time that they had been assessed for. Relatives told us that us that the staffing levels in the home resulted in insufficient supervision to keep people safe. One person said, "It is quite a large building with areas that are not supervised due to insufficient staff available so, I am concerned that staff do not always see what goes on." They told us that a person had experienced a fall in a communal area of the home that had not been observed by staff. Another person said, "I think just two staff on duty at night is not enough to keep people safe." They gave examples where people were at risk of experiencing seizures at night and needed one to one support.

Staff told us that they believed people's safety was not always promoted because the service was short staffed. They said that the safe staffing levels would be six or seven support staff per shift. The manager said that the optimum staffing level would be eight staff on duty during the day and four at night in order to keep people as safe as possible. On the day of our inspection there were four support workers on duty in the morning, five in the afternoon and two at night. The local authority provided funding for two people to have one to one care to meet their needs. This meant that there were two support workers available to meet the needs of the remaining twelve people who were accommodated at the home on this day. The staff members were also responsible for the cleaning of the unit and doing the laundry. The manager did not have the autonomy to secure the services of agency staff; the decision not to use agency staff for additional support had been taken by the provider.

A staff member told us that people's behaviours escalated due to a lack of stimulation and a lack of available staff to take them out into the community and provide engagement. A staff member told us that people's behavioural outbursts were particularly critical and meant that people then required one-to-one support to protect their safety and the safety of those around them. Staff gave us an example where a person had experienced an episode

Inadequate

Is the service safe?

of challenging behaviours and the situation had needed three staff members to support the person safely. This had left one staff member available to support the remaining people in the home. This meant that there were insufficient staff members to safely support people who used the service.

It was not clear how the dependency of each person was assessed to determine the level of support they required and to calculate staffing levels within the home. We found that staffing levels were inadequate and the manager told us that they did not have authority to access agency staff to ensure people's needs were met.

We found that the registered person had not protected people against the risk of receiving care from insufficient numbers of suitably qualified, skilled and experienced staff. This was a breach of regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 18(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

A recruitment drive had been initiated with adverts placed locally and the manager was able to clearly describe the process necessary to safely recruit the right people. However, staff employed prior to the manager coming into post had not always been recruited safely.

Staff demonstrated a good understanding and knowledge of how to safeguard people from abuse. They knew people well and were able to describe the individual changes in people's mood or behaviour and other signs which may indicate possible abuse or neglect. They understood the procedure to follow to pass on any concerns and felt these would be dealt with appropriately by senior staff. Fifteen of the twenty staff employed to work at the home had completed safeguarding training and they were encouraged by the manager to report any concerns. Staff understood their responsibilities around whistleblowing procedures and said they would not hesitate to use them.

Relatives told us that staff knew how to manage accidents and incidents. For example, one person told us that their relative had a recent fall. The staff member had called the relative, told them what had happened and what they had done to ensure the person was alright. Staff confirmed this incident and told us of the monitoring they had put in place to keep the person safe. The manager told us that accidents and incidents were monitored to identify trends and develop actions plans to reduce risks to people's safety and well-being where possible.

Staff told us that three handover meetings took place each day to share information about incidents, people's demeanour, welfare and needs and the manager and deputy were usually present at these. We observed a handover meeting and noted that clear information about people's safety and wellbeing was passed to the staff members coming on duty.

Requires Improvement

Is the service effective?

Our findings

At our previous inspection in August 2014 we identified a breach of regulation 23 in relation to the training and supervision of the staff team. At this inspection we found that there were still some issues remaining in this area.

The staff team were not all up to date with basic core training such as fire safety, infection control, moving and handling and safeguarding. The manager told us that it had been difficult to arrange the necessary training due to the lack of staff. The service employed 20 staff members and as there was a minimum of 11 staff members on duty each day this did not allow flexibility for people to attend training. However, four people were booked to receive induction training in March 2015, five people had been booked onto National Vocational Qualifications and there were plans in place for every member of staff to redo all core training to ensure that their skills were current. We noted that two staff had received training to provide them with the skills to manage the needs of people living with epilepsy. This was a concern as six of the 18 people who used the service lived with epilepsy.

Some staff told us that they did not feel well supported and the manager told us that prior to her coming into post there had been no system of staff supervision in place. Two formal supervisions had taken place in October and two in November but none had taken place since and staff members told us that there had been no staff meetings since Christmas. This meant that staff did not have a formal opportunity to discuss the management of the home, or to raise concerns or suggest improvements.

This was a continued breach of Regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 18(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Relatives told us that people enjoyed the food provided for them and we found that staff supported people to eat and drink sufficient amounts. Where needed, people were assisted to eat or drink in a patient and sensitive manner and we saw that staff encouraged people to be independent. For example, we heard a staff member encouraging a person, “Do you want to try with your spoon?”

We saw that where people had been assessed as being at risk of poor nutrition the services of a dietician had been sought. However, it was not possible to confirm by talking with staff or looking at records that the advice and guidance received from the dietician had been taken into account.

The manager told us that they had researched healthy eating for people who lived with epilepsy and diabetes and identified a selection of menus appropriate for their health needs. A menu had been developed using the healthy eating options, people's choices and pictorial prompts. However, it was reported that the cook had declined to incorporate these options into the menu as it would mean preparing too many different meals. This meant that people did not always receive the support they needed to ensure they received a healthy and balanced diet.

This was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Relatives and the manager told us that discussions with next of kin, social workers, the pharmacist and GP were in progress to enable best interest decisions statements to be put in place to support people who were not able to consent to medications. We found that people’s ability to make decisions had been assessed and saw an example of where a person was deemed to have capacity with regard to the use of bed rails and evidence that capacity had been discussed with the person’s next of kin. However, it was not clear if this information had been subject to review and was up to date. Staff members did not demonstrate an understanding of the Mental Capacity Act (2005) (MCA) and Deprivation of Liberty Safeguards (DoLS) and had not received training in this area. Staff members were not able to explain how they sought people’s consent when they were not able to communicate verbally and we did not observe any examples of this in practice. This meant that the service was not working in accordance with the Mental Capacity Act 2005.

The manager told us that DoLS applications had been submitted to the local authority in relation to every person who lived at the home. The manager told us that people

Requires Improvement

Is the service effective?

had not had social workers involved in their care for some considerable time and that she had been working with the local authority to secure named social workers to advocate for individuals who use the service.

Relatives told us they felt that people's health needs were met. One person told us, "I believe [person's name] health needs are met properly, they look after [person] well." We found that all people who used the service had attended recent dental check-ups and had received medication reviews with the GP. Mental health reviews had been undertaken and a system of three monthly continuous reviews had been put in place. Learning disability reviews had taken place for eight people with eight more scheduled for this month and a full health review had taken place for all people who used the service. Wheelchair assessments had been undertaken, and we saw that this had resulted in an example where cushioned sides had been introduced for one person to increase their comfort because they leant to one side. This meant that people were supported to maintain good health and receive on-going health care services as needed.

Requires Improvement

Is the service caring?

Our findings

We observed some pleasant interaction between people and staff that supported them. Staff clearly understood people's specific needs and methods of communication. However we saw some examples where some staff were brusque with people and gave out instructions as opposed to interacting in a kind and gentle manner. We also observed a physical interaction that was inappropriate and heard staff discussing people's toileting needs in such a way that did not promote people's dignity or respect them.

There were no areas for people to meet with social workers, health professionals or family members in private other than in their own bedrooms. The manager's office was small which meant that meetings that took place in the home had to be held in a communal area. This meant that people's confidentiality may be breached and their dignity was not respected.

People's confidentiality was not always promoted. The arrangements in place to store people's care records, which included confidential information and medical histories, were not effective.

We saw a cupboard in the hallway with people's personal and private information stored in it. The cupboard was stood wide-open despite a sign above it stating it should remain closed at all times in order to promote people's confidentiality. This meant that people's personal and private information was not stored in a manner that respected their dignity.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Relatives told us that the staff team were caring in the majority. One person gave us an example where the family had experienced bereavement and the home manager had arranged professional bereavement counselling to support the person through the grieving process. They said, "They were absolutely brilliant." Another person told us that their family member was always happy to return to Three Oaks after a weekend at home.

Some people who used the service did not have family or friends to support them to make decisions about their care. The manager told us that a local authority representative was supporting the home to access advocacy services to support people to make decisions and communicate their wishes.

People's bedrooms were personalised and individual. We saw that bathrooms were well-equipped to meet people's needs. Relatives told us that they were able to visit people at any time without restrictions.

Requires Improvement

Is the service responsive?

Our findings

People's relatives told us that they had been involved in the planning of their care and that staff kept them up to date with people's health needs. Relatives told us that they were invited to the home to take an active part in meetings with health professionals and care reviews. One person said, "I visit once a week and speak with the manager on the phone once a week, and I get invited to health and review meetings that is how they keep me up to date with their health needs."

We found that care plans contained some useful information about people who used the service however they were not up to date and they were difficult to navigate. The manager told us that care plans were being re-developed from scratch for each person using the information gleaned through the comprehensive health reviews that had recently taken place.

We observed one member of staff de-escalate a situation using distraction techniques when a person became agitated, stamping their feet and waving their arms. This demonstrated that staff understood how to support people according to their individual needs. However, it seemed that the person required more stimulation and there were not enough staff to provide any one to one support. A record of behaviour was being kept for this person on the advice of the GP to try and understand if the behaviour suggested that the person may be in pain.

Relatives told us that there was little stimulation provided for people. One person said, "There is not enough for people to do. The staff are very caring, there are many promises made about taking people out and about, they mean well but it never seems to come to anything." Another person told us, "[Person's name] used to be taken out quite a bit but that does not seem to happen anymore. They don't get taken to the shops any longer." Staff did not offer stimulation to people during the day. Some people fell asleep in communal areas, others became agitated, and some stayed in their rooms. We noted that the provision of activities and stimulation did not increase at weekends when all the people who used the service were at home. This meant that people did not always receive activities and stimulation to keep them engaged.

Staff told us that there were a variety of things that people enjoyed doing when there were enough staff available. These included going for walks, visiting a local wildlife attraction to feed the ducks, going to the pub and going for a drive. One staff member described how they had brought pizza bases into the home and that people had helped to put their own choice of topping on and then the pizzas were eaten for lunch. However, staff told us that the current staffing levels meant that they did not have the capacity to support people to follow their interests on a day to day basis.

Relatives of people who used the service told us that they would be confident to raise concerns with the home's management team. One person said, "I do know how to make a complaint should I need to. I have never felt the need to complain about Three Oaks." There was a complaints policy in place with timescales for a resolution. The manager told us of a complaint that had been received and demonstrated how this had been dealt with and the learning that had been taken forward from the issue.

Inadequate

Is the service well-led?

Our findings

At our previous inspection in August 2014 we identified a breach of regulation 10 in relation to the systems in place to assess and monitor the quality of service. At this inspection we found that there were still some issues remaining in this area.

The manager had taken steps to monitor the quality and effectiveness such areas as people's care plans and staff recruitment practices. The manager had identified that care plans had not been updated and that people's health needs had not been routinely monitored. The manager had addressed this and ensured that every person who used the service had received full health checks and care plans were being re-developed using information from these health checks as a base line. The manager had identified shortfalls in the previous recruitment practices in the home and had put a new system in place to ensure that new staff members would be recruited safely. The effectiveness of this could not be measured at this inspection because there had been no new staff members recruited using the revised practices.

Routine internal audits of such areas as infection control and health and safety were not completed. Medicines management audits were in place however had not identified all areas of shortfall so were not always effective. The provider did not have any arrangements in place to assess the quality of the service provided at the home or to monitor and manage risks to people's health, safety and welfare.

The management team in the home was improving the experience for people who used the service however, the lack of support from the provider both financially and in terms of monitoring the quality of the service did not support these improvements. There was no senior level quality monitoring undertaken to ensure that the processes the manager was developing were effective.

The staff and manager told us that staff meetings were not held and that staff supervision sessions had been implemented but were not yet embedded into practice. This meant that staff did not have a formal opportunity to discuss the management of the home, or to raise concerns or suggest improvements.

This demonstrated a continued breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Relatives gave positive feedback about the new management team at the home. One person said, "It is much better now that [the new manager] is running the home. The previous manager left ever so quickly and [the current management team] took on a shared management role. It seems like there is a huge amount for them to do and they are having to learn on the job. In my perception they are doing their very best." Another person told us, "The current manager is learning, she has the right attitude."

At the time of this inspection the service did not have a registered manager in post. The service was being managed by an acting manager and acting deputy manager who were working hard to drive forward improvements in the service and struggling to cope without support from the provider. The management team told us that they had a number of plans to change the working practices in the service to ensure that the quality of people's lives improved. These included a recruitment drive to increase the number of staff available, additional training for the staff team to increase their skills and knowledge and to increase the numbers of staff on duty so that people could receive the support they needed to access the community and enjoy social engagement.

We spoke with representatives from the local authority commissioning team and community learning disability team as part of this inspection. They told us that they had concerns regarding the service but that the new management team were working hard to drive forward improvement and they were starting to see some progress. However, they also told us that the manager was working excessive hours in order to effect change whilst working alongside the staff team to provide hands on support for people who use the service. They told us that the hours the manager was working to achieve this were not sustainable. This was confirmed by discussion with the manager at our inspection visit.

Staff we spoke with demonstrated an understanding of whistleblowing procedures and said they would be confident to use these if they felt that people were at risk. Where accidents and incidents had occurred we saw that action had been taken to learn lessons from these

Inadequate

Is the service well-led?

incidents. Services that provide health and social care to people are required to inform the Care Quality Commission, (CQC), of important events that happen in the service. The manager had informed the CQC of significant events in a timely way. This meant we could check that appropriate action had been taken.

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	Regulation 17 HSCA (RA) Regulations 2014 Good governance **The registered person does not operate effective systems to protect service users against the risks of inappropriate or unsafe care.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **The registered person did not operate effective systems to protect service users from the risks associated with unsafe use and management of medicines.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA (RA) Regulations 2014 Meeting nutritional and hydration needs **The registered person does not ensure that service users are protected from the risks of inadequate nutrition and dehydration.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect **The registered person does not ensure that service users are treated with dignity, consideration and respect.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing

This section is primarily information for the provider

Action we have told the provider to take

The registered person does not take appropriate steps to ensure that, at all times, there are sufficient numbers of suitably qualified, skilled and experienced persons employed for the purposes of carrying on the regulated activity.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing The registered person does not have suitable arrangements in place in order to ensure that persons employed for the purposes of carrying on the regulated activity are appropriately supported in relation to their responsibilities, to enable them to deliver care and treatment to service users safely and to an appropriate standard, by receiving appropriate training, professional development.