Dorset Healthcare Ltd

Oakdene Nursing Home

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

Oakdene is a residential care home for 71older people. The home consists of two separate buildings within the same grounds and offers both residential and nursing care to older people, some of whom are living with a dementia. At the time of our inspection there were 54 people using the service.

At the last inspection, the service was rated 'Good'. At this inspection we found the service remained 'Good' although some improvement was required in management oversight.

People were protected from avoidable harm as staff understood how to recognise signs of abuse and the actions needed if abuse was suspected. There were enough staff to provide safe care and recruitment checks had ensured they were suitable to work with vulnerable adults. People had their risks assessed and actions to minimise risks were understood by staff and respected people's freedoms and choices. Medicines had been administered safely by trained staff that were aware of the actions needed if a medicine error happened. Staff had completed infection control training and followed procedures that protected people from avoidable infections. The service was responsive when things went wrong and reviewed practices in a timely manner.

People had their needs and choices assessed prior to living at Oakdene and this information had been used to create care plans that recognised people's diversity and lifestyle choices. Care plans had been developed in line with current legislation, standards and good practice guidance. Staff had completed induction and on-going training that enabled them to carry out their roles effectively. People had access to healthcare when needed and working relationships with health professionals enabled effective care outcomes for people. The principles of the Mental Capacity Act 2005 were followed which ensured people had their rights protected.

The environment and use of technology met people's needs and helped them maintain their independence. People had personalised their rooms and some had memory boxes which contained photos and memorabilia that represented past interests and hobbies.

Staff were caring and showed patience and kindness when interacting with people, ensuring people had their privacy and dignity respected. They understood people's individual communication needs enabling people to be involved in decisions about their day to day lives.

Social opportunities included one to one time with staff, group activities in the home and community and fund raising events. Links with the community included providing a place of safety for people with a dementia experiencing a crisis.

Oakdene had not always met their legal responsibilities to share information with CQC in a timely manner. They also were not able to demonstrate processes had been followed to meet regulatory standards when dealing with complaints prior to February 2018. A complaints process was in place that people were aware

of and felt able to use. A complaints log had been commenced from February 2018 which demonstrated people's complaints had been investigated and the appropriate actions taken.

A whistleblowing and grievance procedure was in place but staff had not always felt empowered to use them to report concerns about their wellbeing in the work place. Management changes had taken place which had created a more open and positive culture, improved communication and teamwork.

Further information is in the detailed findings below.

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 remains Good	**Good**
Is the service effective? The service remains Good.	**Good**
Is the service caring? The service remains Good.	**Good**
Is the service responsive? The service remains Good	**Good**
Is the service well-led? The service has deteriorated to Requires Improvement Statutory notifications had not always been sent to the Care Quality Commission in a timely way. Actions identified in quality assurance processes had not always been completed in a timely way. The culture of the home had not always been open and transparent which meant staff had not felt empowered to raise concerns about their well being whilst at work	**Requires Improvement**

Oakdene Nursing Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection began on the 19 April 2018 was unannounced and the inspection team consisted of an inspector and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who used this type of care service. It continued on the 20 April 2018 and was announced.

Before the inspection we looked at notifications we had received about the service. A notification is the means by which providers tell us important information that affects the running of the service and the care people receive. We also spoke with local commissioners to gather their experiences of the service.

The provider had not completed a Provider Information Return prior to our inspection. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

During our inspection we spoke with 12 people who used the service. We spoke with the registered representative of the provider, the director of care, acting manager, administrator, three nurses, nine care staff, two chefs and a member of the maintenance team. We also spoke with an in-reach worker from the community mental health team to gather feedback on their experience of the service. We reviewed eight people's care files and discussed with them and care workers their accuracy. We checked three staff files, care records and medication records, management audits, staff and resident meeting records and the complaints log. We walked around the building observing the safety and suitability of the environment and observing staff practice.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

Good

Is the service safe?

Our findings

People and their families described the care as safe. One person told us "I feel safe here, especially now, as I have had several falls. Staff are always walking past my room keeping an eye on me." People were supported by staff that had completed safeguarding training and understood how to recognise signs of abuse and the actions needed if abuse was suspected. Training had included telephone numbers of external agencies that could be contacted with safeguarding concerns. People were protected from discrimination as staff had completed training in equality and diversity and we observed them respecting people's individuality.

Assessments had been completed that identified risks people experienced. When a risk had been identified actions had been put in place to minimise the risk and they were reviewed at least monthly. Some people were at risk of skin damage. People had the correct equipment such as pressure relieving mattresses and cushions and were helped to change their position regularly. When people were at risk of malnutrition they were weighed at least monthly and actions included high calorie drinks, food fortified with additional calories and referrals to a dietician.

People were involved in decisions about managing risks they lived with. One person was at risk of falling. They decided against bed rails but told staff they preferred an alarm mat beside their bed which would alert staff if they got up. Another person had poor swallowing and a risk of choking and had been advised by the speech and language therapist to have a soft textured diet. The person had stopped enjoying their meals and lost weight. The person with their family, staff and support from the speech and language therapy team decided to return to a normal textured diet. This demonstrated that people had risks managed whilst having their freedoms and choices respected.

Records showed us that equipment was serviced regularly including the lift, boiler, fire equipment, and hoists. People had personal evacuation plans which meant staff had an overview of what support each person would require if they needed to leave the building in an emergency.

People were supported by enough staff to meet their needs. One person told us, "Staffing levels are good and they're always available when I need them". A relative told us "Response time from carers is very quick". A senior care worker told us "there is normally enough staff. If we are short we can borrow from next door (another part of the service in a separate building), which helps". The acting manager explained how staffing levels responded to meeting people's needs. They told us, "Feedback from staff had been that we needed to increase staffing levels to four rather than three care staff due to people's needs increasing. Although dependency has reduced again we have kept the higher staffing numbers and it has led to a better standard of documentation".

Staff had been recruited safely. Relevant checks had been undertaken before people started work. For example references obtained and checks made with the Disclosure and Baring Service to ensure that staff were safe to work with vulnerable adults.

People had their medicines ordered, stored, administered and recorded safely. Some people had been prescribed medicine for as and when required (PRN). Information on the medicine administration record provided details of dose and frequency and staff were able to tell us why a PRN had been prescribed. When people were unable to recognise if they needed a PRN, medicine systems were in place to support medicine administering decisions. One example had been a person who occasionally required a laxative. Staff recorded the person's bowel actions and the information was kept alongside the medicine record to support decisions about administering the medicine. The acting manager told us that more detailed PRN protocols were being introduced which would be more person specific. When people had been prescribed topical creams a body chart had been completed indicating where each cream needed to be applied. Records showed us these were being applied in line with prescription instructions. When a medicine error had been identified staff had followed the reporting process and appropriate actions taken to avoid a further incident and keep people safe.

People were protected from avoidable risks from infection as staff had completed infection control and food hygiene training. We observed staff wearing gloves and aprons appropriately and hand sanitizers and moisturisers available at points throughout the building. All areas of the home were clean and odour free.

When things went wrong timely actions had been taken, lessons had been learnt and appropriate reporting to external agencies had taken place.

Good

Is the service effective?

Our findings

Assessments had been completed before a person moved into the service and this information had been used to form their care and support plan. The plans contained clear information about people's assessed needs and described the actions staff needed to take to support people's needs and choices. One person told us "Care staff are very good at what they do, are well trained and my health needs are being met daily. Care plans had been developed in line with current legislation, standards and good practice guidance. Assessments included determining any equipment needed to support a person such as a hoist or pressure relieving equipment.

Staff had completed an induction and on-going training that provided them with the skills to carry out their roles effectively. Induction for some staff included the Care Certificate. The Care Certificate is a national induction for people working in health and social care who did not already have relevant training. A care worker described their induction, "Training included everything I needed to do. The first two to three weeks was more watching than doing. Everybody was helpful and told me to ask for help. I've completed my Care Certificate". Nursing staff had opportunities to develop clinical skills. One nurse had attended a wound management course and explained how it had benefitted their role. They told us, "Recording is most important. Any investigation about wounds relies on good recording as that makes it easier to establish a root cause and also the effectiveness of treatments". Staff told us they felt supported in their role and had regular supervision. Staff had opportunities for professional development including diplomas in health and social care.

People had their eating and drinking needs met and spoke positively about the food. We observed people having a choice of well-balanced nutritious meals and being offered a choice of drinks throughout the day. Snacks were available at all times such as a bowl of savoury snacks in a quiet sitting area and bowls of fruit on dining room tables. Information about people's health and cultural dietary needs, likes and dislikes had been shared with the catering team. Staff were aware of the people who needed encouragement to eat and drink and completed charts to reflect people's dietary intake. Where people had safe swallowing plans staff were aware of their required textures of food and drink. Some people had specialist crockery, plates and beakers to aid their independence.

Working relationships with other organisations supported effective care outcomes for people. An example included working with community mental health nurses when a person had anxieties that affected their behaviour. Care staff had completed records detailing possible triggers before an anxiety attack, behaviours demonstrated and outcomes of thier interventions. Records reflected that staff responded appropriately to both on going healthcare needs and health emergencies. One person told us, "Care staff are very good at what they do, are well trained and my health needs are being met daily". Each person had a care passport which accompanied them when transferring to another care setting. It included emergency contact information, how to keep the person safe and their likes and dislikes.

Oakdene Nursing Home consisted of two separate buildings. Both provided opportunities for people to access communal areas, private areas and accessible outside space. People had been able to personalise

their rooms with furniture, photos and artefacts. Some people had memory boxes outside their bedroom doors which contained photos and objects related to their lives, hobbies and interests and helped orientate people to thier room.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. We saw that people had MCA assessments in place and that these were decision specific and provided evidence about how the decision had been made. Best interest decisions had included people's families and health and social care professionals who knew the person and their history. Some people living at the service were not able to express their consent verbally. Care and support plans detailed how people communicated their consent. One read '(Name) will hold onto thier clothing if not ready to be assisted with washing and dressing'. Deprivation of Liberty Safeguards had been applied for where a person who needed to live in the home to be cared for safely did not have the mental capacity to consent to this. Files contained copies of power of attorney legal arrangements for people and staff understood the scope of decisions they could make on a person's behalf.

Good

Is the service caring?

Our findings

People and their families spoke positively about the staff team describing them as kind and caring. One person told us, "The attitudes of staff are very caring, friendly and kind; it's never too much trouble to help when I need it". A relative said, "I cannot praise the staff enough for their thoughtfulness, responsiveness and kindness when they support my (relative) daily".

The service met the requirements of the Accessible information Standard. The Accessible Information Standard is a law which aims to make sure people with a disability or sensory loss are given information they can understand, and the communication support they need. People's communication needs were clearly assessed and detailed in their care plans. This captured the person's preferred methods of communication and how best to communicate with them. People had been assisted to keep their glasses and hearing aids in working order. Around the home we saw large boards detailing the date, day and season. People had clocks with large print and telephones with large numbers. Staff used appropriate non-verbal communication to demonstrate listening and to check people understood them. We observed staff talking with people at eye level and using hand gestures and facial expressions.

Staff had a good understanding of people's past history which enabled meaningful conversations. One care worker explained how one person could become anxious and emotional. They told us "(Name) can need a lot of reassurance. (Name) likes horses and I do as well so we talk about that". A book sale was taking place and a carer recognised an author a person enjoyed and popped them around to their room to see if they wanted them.

People were involved in decisions about their care. One person told us "I can have a shower whenever I like; there is no strict routines here". Another explained "The staff always have time to stop and listen when I have wanted to ask questions about my room, personal care or food etc". We observed staff involving people in decisions about their day to day activities and ensuring people were happy to receive any assistance offered. One person told us "Staff are extremely good at helping me to do things at my own pace".

People had their privacy and dignity respected. We observed staff speaking to people respectfully; using their preferred name and giving people time to do things independently when they could. The acting manager told us "It's all about the residents and about being kind". People, their families and staff had been writing their thoughts about what dignity meant to them and hanging them on a dignity tree in the foyer. One care worker had written 'Putting people first'. A relative told us "The staff have treated (relative) with dignity and respect. They are kind, caring and so supportive as my (relative) can have their bad days which is often difficult to deal with". Confidential information was stored in a locked room or stored on password protected computers.

Good

Is the service responsive?

Our findings

People had care plans which reflected their personal care needs and choices and were reviewed at least monthly. Staff understood their role in meeting peoples care needs and choices and told us they were kept up to date with changes. One care worker said "We have handover every morning and if somebody has gone downhill we hear about it. All notes are in every care plan. Communication is pretty good here". Records showed us that people and their families had opportunities to be involved in care plan reviews.

People and their families had contributed to booklets called 'This is Me'. They included photographs of a person through their ages, details of past hobbies, interests and significant events important to them. A care worker explained how the information helped match activities to peoples interests. They told us,"Two men like fishing so we have sourced some fishing books to look through with them. (Name) likes gardening and likes to go out to the garden centre". One person told us, "There are activities organised daily covering a wide variety of topics. I attend them if it's interesting." A wishing tree had been created and people had started to put their wishes on labels and hang them on the tree. One person's wish was to 'Feed the ducks' another 'listen to a choir'. Staff were very engaged in helping people have their wishes fulfilled. Another activity involved a huge map of the world to see how well travelled people were and how much of the globe had been covered. The acting manager explained how it was really good at triggering a lot of long term memories and starting conversations.

We observed people enjoying a game of skittles and helping prepare for a charity 'Pink Day' in aid of breast cancer. Other activities included care workers accompanying people for walks around the grounds, a book sale and a reminiscence sensory activity. People had their religious and spiritual needs respected and an example included people attending a church service held in the home. Links with community included visits from local schools, trips to local shops, local days out to places of interest and church visits.

A new initiative had been introduced called 'Stop at Three'. Every day all staff stopped whatever they were doing and spent 20 minutes with people. A member of the maintenance team shared how they had enjoyed playing virtual boxing with one person on an electronic game. Another person shared how they had enjoyed telling the chef about their ten grandchildren.

A complaints procedure was in place and people and their families were aware of it and felt able to use it if needed. The procedure included details of how to appeal against the outcome of a complaint and provided details of external organisations such as the local government and social care ombudsman. The provider shared statistics with us that showed that between 29 May 2017 and 29 January 2018 the service had received seven complaints. Records were not available to demonstrate any details of the complaint, any investigation of the complaints or response to complainants. We spoke with the providers nominated individual who told us they would have viewed complaints during their site visits and was able to provide details of the content, actions and lessons learnt. We were able to see that the acting manager had begun appropriately recording, investigating and responding to complainants from February 2018.

Records were only available from February 2018. They demonstrated that over a two month period

complaints had been investigated, outcomes shared with the complainant and actions taken to improve the quality of service delivered.

People had an opportunity to develop care and support plans detailing their end of life wishes which included any cultural requirements and decisions on whether they would or would not want resuscitation to be attempted. End of life care had been designed to meet the physical, spiritual and emotional needs of people who are dying, with a focus on the management of symptoms, comfort, dignity, and respect in line with national best practice guidance.

Requires Improvement

Is the service well-led?

Our findings

The service had a registered manager but they were absent from their duties at the time of our inspection. In their absence the deputy manager had taken the role of acting manager.

Statutory notifications had not always been made to CQC. We had not been notified of a police incident at Oakdene. A statutory notification is a legal requirement for the provider to inform CQC of certain situations as part of their oversight of care provision. This meant that we had not received information to support our monitoring of the service. Records showed us that statutory notifications had been sent to CQC in relation to incidents relating to people using the service.

The provider had a whistleblowing policy and staff grievance policy in place which provided contact details of the provider should staff need to raise concerns. Staff had not felt empowered to use these processes to report concerns related to their wellbeing whilst at work. We discussed this with the provider who explained the actions they had taken to promote a more open culture. These had included providing staff with contact numbers for external agencies, offering confidential one to one support meetings to staff during provider visits and staff being offered exit interviews by the personnel team.

An audit had been carried out by the provider in November 2017 but had not led to the registered manager responding appropriately to the actions identified. Auditing systems had been reviewed by the provider and acting manager in February 2018. We saw that these audits were leading to service improvement. An example had been the introduction of a new recording system for the administration of topical creams.

The provider had not carried out a quality assurance survey with people, their families and staff since acquiring the home in March 2017 but told us this was something planned in the future. The service had information in reception detailing how people, their families and staff could provide feedback via a national website.

People, their families and staff spoke positively about the current management of the home. A care worker told us "(Acting manager) is absolutely brilliant. They know this place like the back of their hand. Brilliant with the support, speaks to every individual and always makes it clear we can go and speak to them". Another told us "(Acting manager) is a good manager. You can go to them. They are understanding but professional. Everybody in the team is happier".

The acting manager had kept their skills and knowledge updated. This had included attending professional conferences, accessing information from professional organisations such as Skills for Care and participating in an 'Outstanding Managers Forum'.

Staff told us that communication had improved and there were regular staff meetings which gave them the opportunity to share ideas. One care worker told us "We have more time to talk to people because we are

now more organised". Staff had been involved in creating the values for Oakdene Nursing Home and these were displayed around the service. They included things like dignity, kindness and equality. A residents and relatives meeting had been held the week prior to our inspection which people told us they found useful.

Community links included providing a safe haven status for people living in the community with a dementia. A senior care worker explained, "This means if somebody is lost or had a crisis they can be brought her as a safe haven".

Accidents and incidents were reviewed by the acting manager and used as opportunities to reflect on practice. Data collected for March 2018 had highlighted a higher incident of falls between 1300 and 1900 hours in one particular part of the service. This had led to a decision to provide more activities in that area during the higher risk times. The acting manager told us initial feedback was this was working well.

The staff team worked with other organisations and professionals to ensure people received good care. Records and feedback from professionals indicated that the staff followed guidance and shared information appropriately.