Mr Timothy Maloney

Oaklands Care Home

Inspection report

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Ratings

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

Overall summary

This inspection took place on 14 and 17 December 2015 and was unannounced.

At the last inspection on 30 January 2014 we asked the provider to make some improvements in people's care records, which did not include all the appropriate information to protect people from unsafe care and treatment. At the time of this inspection an improved system of record-keeping had been put in place.

Oaklands Care Home provides accommodation care and support for up to 31 older people, including those who are living with dementia. There were 29 people using the service at the time of this inspection.

The service has a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Consent to care and treatment was not always sought in line with current legislation and guidance. Staff were not able to apply the principles and codes of conduct associated with the Mental Capacity Act 2005.

Summary of findings

The home's environment had not been developed to take into account the needs of the people living with dementia.

Safe recruitment practices were followed and appropriate checks had been undertaken, which made sure only suitable staff were employed to care for people in the home. There were sufficient numbers of experienced staff to meet people's needs.

Staff were supported to provide appropriate care to people because they received an induction and ongoing training and supervision.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which apply to care homes. Where people's liberty or freedoms were at risk of being restricted, the proper authorisations were in place or had been applied for.

People received regular and on-going health checks and support to attend appointments. They were supported to eat and drink enough to meet their needs. The choices of food and drink available were not always clear or offered.

There was a positive atmosphere within the home and people received care and support from staff who had got to know them well. Staff understood people's individual needs and worked in a manner that respected people's privacy and protected their dignity.

The service was responsive to people's needs and staff listened to what they said. Staff were prompt to raise issues about people's health and people were referred to health professionals when needed. People were confident they could raise concerns or complaints and that these would be dealt with.

People and their relatives spoke positively about how the service was managed. The quality of the care and treatment people experienced was monitored and action taken to promote people's safety and welfare. Staff felt they would be supported by the management to raise any issues or concerns.

We found one breach 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?

Good

The service was safe.

Staff understood what constituted potential abuse and their responsibilities for reporting suspected abuse.

Risks to people's health and wellbeing were assessed and monitored and risk management plans were in place.

Staffing levels were sufficient and organised to take account of people's care and support needs.

People's medicines were managed appropriately so that they received them safely.

Is the service effective?

Requires improvement

The service was not always effective.

Consent to care and treatment was not always sought in line with current legislation and guidance.

There was a programme of staff training and development to support staff to gain relevant knowledge and skills.

The environment was not ideally suited to meet the needs of people living with dementia.

People were supported to eat and drink enough to meet their needs. The choices of food and drink available were not always clear or offered.

People had access to healthcare services when they needed them.

Is the service caring?

Good

The service was caring.

The atmosphere in the home was friendly and caring. People received care and support from staff who had got to know them well.

Staff we spoke with demonstrated their understanding of the needs of people who used the service and interacted positively with them.

People's privacy and dignity was protected.

Is the service responsive?

Good

The service was responsive.

Staff were aware of people's care needs and were attentive to their requests for assistance.

Summary of findings

People's needs were reviewed regularly and, where necessary, external health and social care professionals were involved.

People's concerns and complaints were encouraged, investigated and responded to in good time.

Is the service well-led?

Good

The service was well led.

People and those important to them had opportunities to feedback their views about the home and quality of the service they received.

The quality of the care and treatment people experienced was monitored and action taken to promote people's safety and welfare.

Staff felt they were supported by the management team.

Oaklands 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 14 and 17 December 2015 and was unannounced.

The inspection was carried out by an inspector accompanied by 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.

Before we visited the home we checked the information that we held about the service and the service provider, including notifications we received from the service. A notification is information about important events which the provider is required to tell us about by law.

During the inspection we spoke with eight people who used the service and four of their visitors to seek their views about the care and support being provided. We also spent time observing interactions between staff and people who used the service.

We spoke with four care staff, the provider, registered manager and deputy manager. We reviewed a range of care and support records for six people, including records relating to the delivery of their care and medicine administration records. We also reviewed records about how the service was managed, including risk assessments and quality audits, recruitment records for three staff, staff rotas and training records.

Good

Is the service safe?

Our findings

People felt safe living at the home. Their comments included: "I feel safe living here. I can lock the door at night if I want, I press the call bell and they come within seconds"; "I feel perfectly safe, I don't need much help"; and "There is no reason not to feel safe, I love it here". Relatives and visitors we spoke with were also confident that people were cared for safely.

Staff had a good understanding of how to keep people safe and their responsibilities for reporting accidents, incidents or concerns. They knew how to report any suspicion of abuse to the management team and agencies so that people in their care were protected and their rights upheld. Policies were in place in relation to safeguarding and whistleblowing procedures and these were accessible to all staff. Records showed and staff confirmed they had received training in safeguarding adults as part of their training and this was regularly updated.

Risks to people's personal safety had been assessed and plans were in place to minimise these risks. For example, risks associated with falls, pressure areas, malnutrition and choking. There was guidance for staff on what to do in an emergency, including a summary of each person's support needs in the event of a fire. Staff were aware of the risk assessment and management plans in place for people. Handover meetings took place between staff on each shift to help ensure that changes to people's health and welfare were discussed and any new risks were identified and acted upon. The registered manager also held a 30 minute meeting with staff each day at 9 am to discuss what was happening in the home and ensure relevant information was communicated.

Staff acknowledged that some risks to health and wellbeing needed to be accepted and taken, in order to promote and not limit people's freedom and independence. We observed staff encouraging people to walk slowly and carefully to the dining room. A member of staff told us their induction had included how to respect people's independence. They explained the importance of "Not completely taking over" and "Respecting their individuality". A person told us "I can do more or less what I want. I do most things myself".

People were supported by sufficient staff with the right skills and knowledge to meet their individual needs. The staffing levels had recently been reviewed and more staff were being deployed to reflect the increase in occupancy levels. In addition to the regular staff the service employed three bank staff, which meant agency staff were not required to cover shifts. This resulted in continuity of care from experienced staff for people using the service. Staff told us the home was split into three sections and staff were assigned to specific people and tasks. This arrangement was flexible and rotated so that staff got to know all of the people living in the home. Staff also told us the provider's policy was that there had to be at least one member of staff in the lounge at all times to provide care and support when people needed it. During the times we were in the communal areas we observed staff followed this policy. People told us there were sufficient staff to meet their needs. Their comments included "The staff come as quickly as they can, I don't really wait"; and "There are plenty of staff, they are very good and they come quickly".

The service followed safe recruitment practices. Staff told us they had undergone thorough checks before they were allowed to start work. Staff files included application forms, records of interview and appropriate references. Records showed that checks had been made with the Disclosure and Barring Service (criminal records check) to make sure people were suitable to work with vulnerable adults.

There were safe medication administration systems in place and people received their medicines when required. Medicines were stored securely in locked cabinets or a fridge, as appropriate, within a designated room. The medication administration records were appropriately completed. Staff received training in the safe administration of medicines and this was followed by competency checks. We observed the member of staff doing the medicines round wore a tabard stating 'do not disturb', to indicate to others that they should not be distracted form this task. Records showed that medicines were audited regularly. People had their medicines reviewed at least annually with their GP. A person told us "I get my medication at the same time every day and there has never been a mistake". Another person said "I can ask for painkillers if I want them".

Requires improvement

Is the service effective?

Our findings

People and their relatives spoke positively about staff and told us they were skilled to meet their needs. Comments included: “The staff know what they are doing, they are very well trained"; "The staff know me very well"; and ""They support her well” and “Meet all her needs”.

Staff told us they had the training they needed when they started working at the home and were supported to refresh their training. We viewed the training records for staff which confirmed staff received training on a range of subjects that included safeguarding, dementia awareness, fire safety and moving & handling. New staff were supported to complete an induction programme before working on their own. The provider had introduced for all staff the new national Care Certificate which sets out common induction standards for social care staff. Records of supervision and appraisal meetings showed staff were supported to keep their training up to date and encouraged to undertake relevant qualifications in health and social care. Staff told us the training helped them to understand and meet people’s needs. For example, they explained how they approached and communicated with individuals who were living with dementia.

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.

The service had a lead member of staff on MCA and staff had received training. However, we found there was a lack of understanding in the application of the MCA for some people’s care and treatment decisions. Some people had capacity to make decisions but had mental capacity assessments on file. The first principle of the MCA is to presume capacity. Where best interest decisions had been made, these were sometimes documented without any assessment of whether the person had capacity to make that particular decision. We found one person had signed their consent to bed rails but subsequent reviews of this decision did not take into account the consent of the person or their capacity if this had changed. This person’s capacity to make decisions about liquidised food and drink was also not clear from the best interest decision documentation. Another person had a mental capacity assessment for medicines but their records indicated they had capacity. Records also did not show that other, less restrictive options had been considered as part of the process. Bed rails and a recliner chair were in use to support people safely but the documentation was not clear if other options had been explored as part of the decision making.

The involvement of relatives in the best interest decision making was not clear. It was not clear in the records viewed if some relatives were being asked to consent to the best interest decision. In other records, it was not apparent that friends or relatives had been involved in the decision.

The failure to act at all times in accordance with the Mental Capacity Act 2005 was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff recognised that people could make some decisions but not others and supported people to make as many decisions as possible. People told us their consent was asked. One person said “Permission is always asked and they always knock on the door”.

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. The registered manager had identified a number of people who they believed were being deprived of their liberty. They had made DoLS applications to the supervisory body.

The home’s environment had not been developed to take into account the needs of the people living with dementia. Some of the corridors were dark with nothing of interest on the walls. There were no items around that people could pick up and use. There was a mirror at the end of a long corridor which made it look as if there was another corridor beyond it and this could be confusing. The signage on the bathroom and toilet doors did not stand out in a way that

Is the service effective?

would support people living with dementia to recognise these areas of the home. We discussed this with the registered manager who said they would consider this but there were no clear improvement plans for the service.

We recommend that the service researches and adopts current best practice in relation to environments to meet the specialist needs of people living with dementia.

At 11:20 we observed one person in their bedroom. There was no drink in their room and their fluid chart record stated they last had a drink at 8am. We observed the person again at 12:15 when care staff came and got them up and down to the dining room in a wheelchair. After 1pm when lunch was finished, we saw the record had been retrospectively completed and stated the person had drunk 50ml of fluid at 10am and 175ml at 12 noon. There was a note on the front of the file telling staff to record as they gave meals and drinks. We raised this with the registered manager, who told us she continually addressed record-keeping with staff. We saw staff meeting minutes confirming this.

We observed the lunch time meal. The tables were laid with tablecloths and cutlery. The food was served on warm plates by the registered manager, who asked each person if they wanted a small or large portion. The registered manager told us she served the lunches as she liked to monitor that people were receiving sufficient nutrition and their food preferences were being met.

The meal was home cooked and looked nutritious. There was no waste and people we asked all said they enjoyed the meal. The chef joked and chatted with people and people appeared to have a pleasant dining experience. The registered manager and staff also chatted to everyone and asked if anyone wanted seconds.

Some people preferred to eat in their own rooms and we saw everyone had food. People who required assistance to eat were supported to do so, either in the dining room, lounge or in their own rooms. Staff were patient and kind in their approach and explained to people what was on their plate.

The majority of people spoke positively about the food and drink provided. Their comments included: “There is always fresh squash in my room and we get tea and coffee delivered to us. If I want a drink I only have to ask, nothing is too much trouble”; “The food is nice here. Sometimes I need help and they help me”; and “There is plenty to eat and drink. You don’t get a choice but if you don’t like what is on offer the chef will make you something else”. One person wanted porridge and was given this. Another person told the chef “Smashing dinner” and asked if they could have the crumble and custard without the fruit, which the chef confirmed and provided. Another person told staff “The food was lovely”. Staff asked people if they had enough to eat.

Relatives were positive about the mealtimes. One told us “I come every day to feed (their relative). The staff are amazing. They always make me welcome and they provide a meal for me. They discuss all her treatment with me. She is not so well today so the doctor has been called”. “The staff feed my wife if I am not here, they support her well. I tell them every day what she has eaten”.

Staff explained that people’s food preferences were recorded as part of their initial assessment. Staff understood that people’s choices may change and alternatives, such as omelettes or sandwiches, were offered if people did not want the meal that was provided. However, we found this was not the case for everyone. One person told us “I don’t like the food here. They never ask what food I like”. Another person said ““I don’t like pork so I only had vegetables today”. A record for this person stated they did not like pork, which was served for lunch on the first day of the inspection. A relative said “The food is good. No choice but he gets enough". We observed people in the dining room were given water to drink, with no other choices being offered, while people in the lounge had juice or water drinks in front of them.

We observed staff discussing the lunchtime menu with people during the morning. Staff told us that alternatives were available in addition to the main menu. However, the absence of pictorial menus or other prompts could mean that people living with dementia were not aware they could request alternatives. We discussed with the registered manager the possible use of picture menus to promote choice for people living with dementia. The registered manager said she would look into this.

Kitchen staff had a list of people’s dietary needs, likes and dislikes and care staff we spoke with were aware of these. For example, those people who required nutritional supplements.

Requires improvement

Is the service effective?

People had access to healthcare services and, where necessary, a range of healthcare professionals were involved in assessing and monitoring their care and support to ensure this was delivered effectively. This included GP and community nursing services, speech and language therapist, chiropody, occupational therapists, opticians and dentistry. People's comments included:

"I can get anything I want in here and if I don't feel well they get me a doctor"; "I didn't feel too good last week and they got the doctor to me straight away. Nothing is too much trouble. I feel OK now"; "The chiropodist came last week. I can see a dentist and an optician if I want one"; and "The doctors come to visit often".

Good

Is the service caring?

Our findings

People told us they were happy with the care they received. Their comments included: "They are very caring. I am waiting for a shower and they will come with me. They listen to me and they know what I like"; "The staff are very kind and caring to me, nothing is too much trouble"; and "The staff I have had so far are very kind and caring". Relatives and visitors spoke positively about the care provided by staff. One relative said "I think the staff are very caring here and we are happy with the home". Another relative told us "The staff are very kind and caring and they understand my wife's signals, she can't speak anymore".

We raised some issues with the registered manager who dealt with these immediately. One person told us they did not like being called 'granny' by a member of staff. The registered manager said she would address this with the staff member. We also observed a stool chart displayed on a noticeboard in the corner of the lounge. This was not conducive to peoples' dignity and the manager agreed to remove it.

The atmosphere in the home was friendly, calm and caring. Staff we spoke with demonstrated their understanding of the needs of people who used the service and interacted positively with them. A member of staff told us about how they provided care for a person living with dementia, whose communication could be repetitive: "I always act as if it's the first time they have told me that". We observed another member of staff sitting supporting a person and asking if the person was feeling better. On three occasions we observed staff as they supported people to mobilise using a hoist. This was done carefully and respectfully, with the staff reassuring the person and explaining what was happening at all times. The people being hoisted appeared calm and relaxed.

People received care and support from staff who had got to know them well. The relationships between staff and people receiving support demonstrated dignity and respect. The care staff were kind and courteous and we observed they knocked on doors before entering people's rooms. Staff gave examples of respecting people's privacy and dignity, for example keeping a person covered as much as possible while assisting them to wash. A person who had a visual impairment told us "The staff respect me and treat me with dignity. They know what I like to wear and they choose my clothes". Another person said "They always knock on the door and ask my consent. If the staff have time they sometimes sit and chat". Relatives and visitors said they felt people were treated with dignity and respect.

People's records included information about their personal circumstances and how they wished to be supported. The records showed that people's family and friends were asked to provide details about them to build personal profiles that would inform their care plans. A relative confirmed they were involved in their family member's care and said "It's brilliant". A person using the service told us "The staff are good. We discuss and work my care out together". We observed the person discussing their medicines with the registered manager.

People's preferences and choices for their end of life care were recorded and reviewed as part of their care plans. A relative told us "They are all very respectful to (the person) and treat her with dignity. All her advance decisions have been written down". Information about making funeral arrangements, religious and cultural practices and rituals, was available in the home.

Good

Is the service responsive?

Our findings

Before people moved into the home they and their families participated in an assessment of their needs to ensure the service was suitable for them. This information was used to develop a personalised care plan. Involving people and their relatives or representatives in the assessment helped to make sure that care was planned around people's personal care preferences. A person who had recently been admitted to the home was discussing their care plan with a friend, who was helping them with the transition.

We saw in some bedrooms people had 'This is me' profiles, which included a summary of their needs with information such as how they liked to be supported by staff. Where people required support with their personal care they were able to make choices and be as independent as possible. One person told us "The staff always ask my consent. I don't need much help but I do need my back dried and they do that very well".

Staff were aware of people's care needs and were attentive to their requests for assistance. For example, we observed a person asking a member of staff to assist them to the toilet. The member of staff acknowledged the person's request, finished answering another person's question and then returned straight away to assist the person to the toilet.

People's needs were reviewed regularly and, where necessary, external health and social care professionals were involved. For example, a person's care records showed staff were monitoring their mobility on a daily basis following changes in the person's health. Another person had been referred to the community mental health team in relation to their deteriorating memory and fluctuating confusion. One person was in hospital at the time of the inspection and the registered manager was making arrangements to visit them and assess their needs prior to their discharge. Handover between staff at the start of each shift ensured that important information was shared, acted upon where necessary and recorded to ensure people's progress was monitored. Relatives told us they were kept informed and updated when people's health needs changed.

People had a range of activities they could be involved in if they wished. An activities programme for the week was advertised on a noticeboard in the home. Activities included: skittles and visual stimulation; hairdressers and art and craft; reminiscence singing old time songs. A member of staff said "Care staff do activities each day". Another member of staff said "There's a nice atmosphere in here. I'm always singing and dancing. There's always something going on, but you can't make people join in". They told us about activities that were provided for people's mental and physical stimulation, for example gentle exercise with balloons. We observed staff joining in with people doing activities in the lounge, including a ball game that would help promote and maintain hand/eye coordination. Another member of staff told us about seasonal activities such as making Christmas cards and decorated Easter eggs. We saw photographs of a Christmas pantomime that had taken place at the home.

Two people we spoke with did not feel there was much for them to do. One person told us "The staff do listen to me but whether it changes anything is another matter. I rarely sit in the lounge. There are no activities that I know about and most people aren't able to speak to me in the lounge". Another person said "There is not much to do all day, but I get visitors and that is good".

People's concerns and complaints were encouraged, investigated and responded to in good time. There was a complaints procedure and a copy was displayed in the home. The complaints record log showed that any complaints received were recorded, investigated and the outcome fed back to the complainant in a timely manner. Examples of action taken in relation to complaints were the purchase of new furniture; and a person moving to a downstairs bedroom. People's comments included "I have never made a complaint, if I have something to say I say it, I tell them at the time"; "I would complain to the office. I have never had to"; and "I would complain to the manager if anything was wrong".

Good

Is the service well-led?

Our findings

At the last inspection we asked the provider to make some improvements in people's care records, because we found that records did not include all the appropriate information to protect people from unsafe care and treatment. The provider and registered manager told us they had implemented an improved system of record-keeping and we saw evidence of this during this inspection. Risk assessments and management plans were in place and kept under review. People's care plans were updated to reflect changes in their health and care needs.

People spoke positively about the overall quality of the service and how it was managed. Their comments included: "So far it is so good, very satisfactory I should say"; "I can't find anything to grumble about. The manager knows what is going on and they all work as a team"; "The manager comes to see my sometimes and asks if all is well"; and "I know the manager and I think this home is well led". Relatives and visitors comments included: "There is good communication with the manager and this home is very well run. She has her finger on the button at all times and she misses nothing. This is a happy home and they all work as a team; they are always happy and joking"; and "They always take notice of what I say. The manager has her finger on everything and she deals with things as they crop up".

People and those important to them had opportunities to feedback their views about the home and quality of the service they received. We looked at the 24 responses from a satisfaction survey carried out in 2015. The survey asked people and their representatives to rate and comment on aspects of the service such as the environment, the complaints procedures and whether staff were respectful and offered choices. We saw that the overall responses were complimentary. The registered manager told us that when comments were made to suggest improvements she acted on this. For example, one person had commented that they did not wish to be supported by male care staff for their personal care and this had been acted upon.

The quality of the care and treatment people experienced was monitored and action taken to promote people's safety and welfare. An external consultant carried out an annual audit of the processes used by the provider to manage the regulated activity, such as the policies and procedures used and the management of the environment. The last audit report showed that no actions had been identified. A maintenance book was kept to record all requests and needs regarding the up keep of the home and we saw that actions were signed off when completed.

Staff were empowered to contribute to improve the service. A member of staff told us the management were approachable and responded to and resolved any issues quickly. They added: "You can be honest with them". Another member of staff told us about regular staff team meetings, which provided staff with updates and gave them an opportunity to give feedback about the service. They added: "And it's listened to", and "If something's bothering me, all I have to do is knock on the door". We saw records of staff meetings that contained discussions about aspects of care delivery, including the importance of good record keeping, encouraging fluids, and care planning.

The registered manager held a 30 minute meeting with staff each day at 9 am to discuss what was happening in the home. The manager told us she made sure at this meeting that staff had breakfast, ready to face a busy twelve hour shift. There were clear lines of accountability within the service with each shift having a clearly designated member of staff in charge. Probationary evaluations were followed for all new staff and we saw that staff performance issues were addressed in line with company policy.

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 11 HSCA (RA) Regulations 2014 Need for consent How the regulation was not being met: Consent to care and treatment was not always sought in line with current legislation and guidance. Staff were not able to apply the principles and codes of conduct associated with the Mental Capacity Act 2005. Regulation 11(1).