Aplin Care Homes Limited

Oxley Lodge

Inspection report

453 Stafford Road
Oxley
Wolverhampton
West Midlands
WV10 6RR

Tel: 01902398112

Date of inspection visit:
08 February 2017

Date of publication:
18 May 2017

Ratings

Overall rating for this service	Requires Improvement

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?	Requires Improvement

Summary of findings

Overall summary

This unannounced inspection took place on 8 February 2017. At our last inspection visit in November 2015 we found the provider was meeting the requirements of the law. Oxley Lodge is a residential care home which provides accommodation and personal care for up to 58 older people some of which may have dementia. At the time of our inspection 48 people were living at the home.

At the time of our inspection there was not a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The provider had appointed a home manager who told us they had recently submitted the appropriate documents to register them as the registered manager for the service.

People told us they felt safe living at the home. Staff knew what action to take if they had any concerns about people's safety. People's risks had been assessed and were appropriately managed and staff had a good understanding of how reduce the risks to people. People received their medicines as prescribed by trained staff and there were systems in place to ensure people's medicines were managed safely.

People were supported by sufficient numbers of staff who had been safely recruited. People were supported by suitably skilled staff received appropriate support and training to enable them to effectively meet people's needs

People were asked for their consent before staff provided care. The principles of the Mental Capacity Act were not being applied and we found the provider was in breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, need for consent. People had sufficient to eat and drink and had access to healthcare professionals when required.

People were supported by staff who were kind and caring and respected people's choices. People's right to privacy and dignity was promoted and people were encouraged to maintain their independence.

People were supported by staff who understood their needs and preferences. Care needs were regularly reviewed and people and their relatives were invited to contribute to the care review process. There had been improvements made to the range of activities available for people to participate in. People and their relatives knew how to complain and felt confident that their concerns would be appropriately managed and resolved.

The provider did not have systems in place to ensure people's rights were upheld where they lacked capacity. Staff understood their roles and responsibilities and felt supported by the registered manager. There were processes in place to gather feedback from people, their relatives and staff, which was used to make improvements to the service. Audit systems were effective at identifying the improvements required

and appropriate action was taken to ensure improvements were made.

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.

People said they felt safe. People's risks were assessed and appropriately managed. People were supported by sufficient numbers of staff who had been recruited safely. People received their medicines as prescribed.

Is the service effective?

Requires Improvement

The service was not always effective.

The principles of the Mental Capacity Act were not always understood or applied to practice. People were cared for by staff that were suitably trained and supported. People were offered a choice of food and had access to healthcare professionals when required.

Is the service caring?

Good

The service was caring.

People were supported by staff that showed kindness and respected people's decisions. People were involved in making choices about their care and support. People's privacy and dignity was maintained and their independence was promoted.

Is the service responsive?

Good

The service was responsive.

People were supported by staff who understood their care and support needs and preferences .Care was provided in a way that reflected people's needs. People had access to activities within the home. People and their relatives knew how to raise a concern or complaint and felt confident to do so.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

The provider did not have adequate systems in place to ensure

people's rights were protected when they lacked capacity. People felt the service was well managed. There were systems in place to gather people's experiences of the service. Staff were aware of their roles and responsibilities and felt supported by the management team. There were effective systems in place to monitor the quality of the service people received.

Oxley Lodge

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 08 February 2017 and was unannounced. Before the inspection the provider completed a provider information return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and the improvements they plan to make. We also reviewed the information we held about the service. This included any statutory notifications we had received. These are notifications the provider must send us to inform us of certain events, such as serious injuries or allegations of abuse. We spoke with the local authority to gain their views about the quality of the service provided. We used this information to help us plan our inspection of the home.

The inspection team consisted of two inspectors and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of service

During the inspection we spoke with four people who lived at the home and eight relatives. We spoke with three members of staff and the activities coordinator. We also spoke with the home manager the deputy manager and a visiting health professional. We reviewed a range of records about how people received their care. These included five people's care records and medicines administration records. We also reviewed two staff files and records relating to the management of the service such as, complaints, accidents and incidents and audit and quality checks.

Good

Is the service safe?

Our findings

People told us they felt safe and relatives felt their family members were safe at the home. One person said, "Safe, why not? Why wouldn't I be safe here? It is warm and cosy. The place itself makes you feel safe". One relative said, "[Person] is safe, I've never seen any sign of neglect, always spotlessly clean". Staff we spoke with had a good understanding of how to keep people safe. They were able to describe the different types of abuse and told us they were confident to report concerns about people's safety. One staff member said, "I would go to the manager to report concerns. I would escalate to the safeguarding team and the owner if no action was taken". Another staff member said, "I would whistleblow". Whistle- blowing means raising a concern about a wrong-doing within an organisation without reprisal. The home manager had a good understanding of their responsibilities to keep people safe. Records we looked at showed they had taken appropriate action where people were at risk of harm or abuse. For example, referring concerns to the Local authority safeguarding team. This showed there were procedures in place to ensure people were protected from harm or abuse.

People were supported by staff who demonstrated a good understanding of their individual risks and how to manage them. A relative we spoke with told us how the staff used safe practices when using hoists. They said, "When I have seen them hoisting I have been impressed. They take due care and attention." Staff we spoke with were able to tell us about people's risks and how to manage them. We observed staff working in ways that reduced these risks. For example, we saw staff supported people to walk or and ensured people had any walking aids within easy reach. Staff were able to tell us about people who were cared for in bed and of how they worked in ways to minimise the risk of pressure sores. The records we saw confirmed staff working practices kept people safe. For example, people who were cared for in bed were being repositioned at the recommended intervals. Staff monitored people's food and fluid intake where they were at risk of poor hydration or nutrition. People's risks were documented and regularly reviewed in response to any changes. For example, we saw changes to people's mobility and equipment used for transferring safely were documented and we observed staff working in ways which were reflected in people's care plans. This meant staff supported people to manage risks to their safety and regularly updated the information they held on peoples care plans.

Accidents and incidents were documented and we saw appropriate action was taken by the home manager to ensure people remained safe. For example, required maintenance work had been carried out, changes were made to the way care and support was provided and referrals were made to appropriate healthcare professionals where required. This showed incidents were monitored and action taken to minimise risks to people.

There were mixed views from people and their relatives with regards to staffing levels. Some people and their relatives told us they felt there were enough staff to meet their care and support needs. One person told us, "I feel there is enough staff". A relative we spoke with said, "I find there is quite a lot of staff, always someone to help". Other people and relatives felt staff were sometimes busy and this meant they occasionally had to wait for support. For example, at mealtimes or in the mornings. One person said, "I get tired waiting for dinner, I know they do the best they can but you do wait a long time". A relative said,

"Generally I would say there is enough staff. From time to time they are stretched, not too many times. It seems to have improved". Staff we spoke with felt there were enough staff to keep people safe and meet their needs. A member of staff said, "We have enough staff now to keep people safe". The home manager told us staffing levels were reviewed regularly and were based on the individual dependencies' of the people living at the home. They told us, "I would increase the staffing levels if we had a person who required end of life care or had complex needs. I would increase staff levels to keep people safe". The registered manager had sufficient processes in place to cover staff absence. We observed care throughout the day and found, overall, there was adequate numbers of staff on duty to promptly assist people with their care and support. This showed that people were supported by sufficient numbers of staff to keep them safe and meet their needs.

People were supported by staff who had been safely recruited. Staff had pre-employment checks completed before they could start working at the home. These checks included references from previous employers and Disclosure and Barring Service (DBS) checks. DBS helps an employer make safer recruitment decisions and prevents unsuitable people from being recruited. Records we looked at confirmed pre-employment checks had been obtained before employment commenced.

People received their medicines as prescribed by staff that had been trained and assessed as competent. One person told us, "I take tablets for blood. I trust them [staff] with that. I have no trouble taking my medication". A relative we spoke with said, "I have no concerns about [person's] medicines". We observed people being given their medicines and saw this was done in a safe way. For example staff stayed with people until they had taken their medicines and medicine records were signed once staff had confirmed the medicine had been taken. People were offered medicines that were prescribed to be taken as and when required in accordance with guidelines. For example, pain relief. Medicines were safely stored and disposed of and there were effective systems in place to ensure people's medicines were being given as prescribed.

Requires Improvement

Is the service effective?

Our findings

People told us staff sought their consent before providing care and support. A relative said, "Staff ask [person] for their consent. Once I asked for [person] to be taken to the hairdresser but they refused and staff respected this decision". Staff understood the importance of gaining people's consent and gave us examples of how they did this. One staff member said, "If a person refused support I would leave them and try later, ask another member of staff or a family member. I can't ever force anybody into doing something". During the inspection we saw examples of staff seeking people's consent to care and support. Staff communicated appropriately and allowed time for people to respond before attending to their needs.

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 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 interest 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 to see fi the provider was appropriately applying the principles of the MCA and found they were not.

Although the registered manager had a good understanding of the principles and application of the MCA we found these were not being applied. Staff we spoke with told us they had not received training in MCA. They demonstrated a limited knowledge of the MCA and how to apply this in practice when people lacked the capacity to make decisions for themselves. For example, staff we spoke with told us that they would gain consent from a family member if a person was unable to make a decision for themselves. Staff were not aware of the need to check that family member had the legal right to make decisions on people's behalf. They were not aware of the need to make decisions in people's best interests or complete an assessment of people's capacity where it was deemed that they lacked capacity to make a decision for themselves. Capacity assessments had not been completed where it was deemed people lacked capacity to make specific decisions for themselves. We also found there was no record of the consideration that had been taken to ensure that decisions were made in people's best interests. For example, we saw one person had bed rails in place to prevent them from falling from the bed. The home manager told us the person was unable to consent t the use of the bedrails. However there was no evidence of this decision being made in the person's best interests. We found the provider was not checking that relatives who were making decisions on people's behalf, had the legal right to do so. The provider had also not considered the use of a DoL's where it was considered people may be being deprived of their liberty. This meant we could not be certain that people's rights were being protected.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Need for consent.

People were supported by staff who were skilled and knowledgeable to deliver personal care. A relative we spoke with said, "Staff are great they are well trained". Staff we spoke with told us they received an induction

to the role before they were able to work with people unsupervised. This consisted of training and shadowing a more experienced member of staff. Staff were required to complete the Care Certificate. The Care Certificate is an identified set of standards that care staff should adhere to when carrying out their role. Staff had access to a variety of ongoing training which enabled them to feel confident to support people's needs. One staff member said, "Dementia training helped me to put myself in people's shoes, I am more aware of their perceptions of the environment and how I need to interact with them". We observed staff using the training they had received in their practice. For example, safe moving and handling practices. Staff told us their competency was regularly checked to ensure they were providing effective care and support to people. Staff told us they were happy in their role and felt well supported. Staff received regular support in the form of one to one supervisions with their line manager. A staff member said, "Supervisions are good, I air my views, they listened and tis can result in change. I have been well supported". This showed the staff felt supported by the provider and had been given the opportunity to gain the skills and knowledge to support people effectively.

People were supported to eat and drink sufficient quantities and had a choice of food and drink. One person said, "The food is lovely, food is wonderful". Another person said, "The dinners are getting better and better. It's getting a lot better. I like to eat and I pick my own meals. They come in and give you drinks and you get a cup of tea". People were provided with a choice of food from the daily menu and staff told us alternatives could be requested if people preferred. A relative confirmed this. They told us, "Staff do [person] something else if [person] doesn't like the food". People who required a specialist diet, were catered for. For example people living with diabetes were provided with a low sugar diet.

People were supported to access health care professionals when required. People told us they had access to a range of healthcare professionals such as GP's, district nurses, opticians and chiropodists. A relative we spoke with told us, "The slightest sign something isn't right they call the doctor or the district nurse". During the inspection we saw the doctor visiting a person at the home following concerns raised by staff about deterioration in a person's health. The home manager had also contacted 111 to seek medical advice for another person where their psychological state had deteriorated. This showed that staff were prompt to seek assistance from healthcare professionals when required. Guidance provided by healthcare professionals was recorded in people's care records for staff to refer to and we saw staff followed this guidance to ensure people's health was maintained.

Good

Is the service caring?

Our findings

People told us staff were approachable and friendly and they were well cared for. One person said, "I am very grateful, they look after me well" A relative told us, "Staff are very efficient. They are very good with [person]. Sometimes [person] is spoilt. They handle them with care and consideration". Another relative said, "The care is very good and [person] is well cared for". Throughout the day we saw positive interactions between people and staff. Staff took the time to speak with people and regularly checked if they were okay or needed anything. We saw one person who became upset and anxious. A staff member sat with this person speaking kindly to them and offering reassurance. We observed the person responded positively and became visibly less anxious and began smiling. We saw another person who staff observed looked cold. The staff member asked the person if they were warm enough and if they wanted a blanket.

People were encouraged to maintain relationships that were important to them and visiting relatives told us how they were made to feel welcome. One relative said, "It's open visiting, you always feel welcome. Staff will offer you a drink or you can just help yourself". Our observations confirmed what relatives told us. We saw relatives visiting the home at various times during the day and being made to feel welcome.

People we spoke with told us they were involved in choices about their care and staff respected their choices. A relative said, "Staff give [person] choices and the respect the decisions [Person] makes". Another relative told us, "My impression is that they ask [person] when they want to go to bed. With the meals, the kitchen staff will ask, 'what would you like"? Throughout the day we saw people being offered a variety choices about their care and support such as how they would like to spend their time, if they would like to take their medicines, what they would like to eat and drink and whether they wanted to engage in group activities. We observed a staff member asking a person if they would like to sit down or if they preferred to stay with them as they were going about their duties. We also observed a staff member had noticed a person was falling to sleep at the dining room table. The staff member asked them if they would like to go somewhere more comfortable or have a pillow. The person declined the offer and staff respected their decision. This demonstrated that staff respected people's choices.

People were supported to maintain their independence. One person said, "The staff help me get up and cleaned. I can give myself a shower and get dressed, I want to do it". A relative we spoke with told us how their family member was encouraged to carry out personal care independently. They said, "They encourage [person to maintain their independent skills". We saw one person who had a visual impairment was supported to make their own hot drinks Staff explained how they supported people to maintain their independence such as, encouraging people to do as much for themselves as possible and prompting only when required. One staff member said, "We encourage [person] to walk to the toilet. Another person makes their own hot drink and we encourage people to wash themselves".

People were treated with dignity and their privacy was respected. We observed staff respecting people's privacy. For example, knocking on doors before entering people's personal space and personal conversations were held discreetly. We also observed the use of privacy screens in lounge areas when visiting professionals were attending to people. The home had an area that could be used for people to have

time with their relatives or healthcare professionals in a private space if people preferred. Staff we spoke with understood the importance of working in ways to maintain people's privacy and dignity and gave us examples of how they did this, such as closing doors and curtains when carrying out personal care.

Good

Is the service responsive?

Our findings

During our last inspection which took place on the 26 November 2015, we rated the home as 'requires improvement' for the responsive domain. This was because people did not have sufficient activities available to them to participate in. People were not encouraged to follow personal interests or hobbies. During this inspection we found the opportunities for people to engage in activities which they enjoyed had improved. One person we spoke with said, "If say what I would like, they'll organise it for me. Occasionally they have various things like some activity. I would rate the activities 9 out of 10. I take to whatever they put on. They know me and if I say something they take note and change it. Most of the time they organise everything I suggest. They do take note". A relative we spoke with said, "There is lots of entertainment, always something on. [Person] enjoys music, singing and dancing, they get to do this". They went on to tell us how their family member was taken out for walks, to the local shops, restaurants and for day trips. We observed a range of activities taking place throughout the day. For example, games, music, singing and dancing. The provider employed an activities co-ordinator. We spoke with this staff member and they told us they scheduled activities that reflected people's personal interests and hobbies. One person said, "I read a lot, I like any kind of mystery books. The activity coordinator is very knowledgeable about books. She will say 'give me a clue' and she'll come back with the book I want. She is very helpful. I've got a cassette recorder and she'll organise the tapes for me". This showed that people had opportunities to participate in activities which they enjoyed and supported their personal interests.

People and their relatives told us they were involved in the assessment and review of their care. A relative we spoke with said "I am consulted with in regards to making decisions about [person's] care. The communication between staff and the family is good". They went on to say, "We have meetings with the staff and we can input into [person's] care plan". Staff we spoke with knew peoples care and support needs well. They were able to tell us about people's likes and dislikes and how they preferred their care to be delivered. A relative we spoke with confirmed that staff had a good understanding of their family member's needs and preferences. They told us that staff provided care and support in a way that reflected how the person used to live before being admitted into the home. They said, "Staff know [person] likes to go to bed early and get up early because that's what [person] used to do". They went on to say, "[Person] has a cooked breakfast every morning like [person] did at home every day of their life". Records we reviewed confirmed what staff had told us about peoples care and support needs and preferences. Care records were regularly reviewed to reflect peoples changing needs and associated risks. Staff communicated changes in people's needs through a variety of communication systems. For example, staff handover at the start of each shift and team meetings. This meant people were cared for by a staff team who were knowledgeable about people's changing care and support needs and preferences.

People's religious preferences were catered for. For example, people had visits from members of their church. One person told us, "I used to church at [place]. The minister comes in for a service occasionally". People were provided with a choice of a male or female carer and this preference was respected. For example, we saw people who preferred female carers to deliver their personal care were provided with them. People were communicated with In ways they preferred. For example, where staff were supporting people who used English as a second language, staff had been given simple phrases for them to refer to in

order to more effectively communicate with people. We observed staff communicating with people in their preferred language during the inspection.

People and their relatives knew how to raise a concern or complaint and felt confident to do so if required. People we spoke with told us they did not have any complaints but told us they would feel confident raising a concern with members of staff. They also told us they had confidence their concerns would be addressed. A relative we spoke with said, "I would go to the office, I would say if I had a complaint, they encourage you to complain. I wouldn't feel bothered about making a concern known". The provider had a process in place to ensure complaints were appropriately managed. Records we looked at showed complaints were documented, investigated and appropriate action taken was to resolve issues.

Requires Improvement

Is the service well-led?

Our findings

The provider did not have adequate systems in place to ensure people's rights were protected where they lacked capacity. We spoke to the home manager about our concerns. They told us they had identified this as an area that required improvement and told us about their plans to train staff and make the necessary improvements.

People we spoke with felt the home was well-managed and the home manager and staff were friendly and approachable. One person said, "I think this is a very nice place. I think this is the best place in Wolverhampton. It's my home now". Another person said, "They [staff] are all good. You can ask any of them if you need anything. I don't think anything could be better". Relatives we spoke with said they knew who the home manager was and expressed confidence in them. A relative said, "The manager has made positives moves and the home has improved". Another relative told us, "The manager is absolutely brilliant; since they have been here things have improved tremendously. There has been a change in the staff, they are more organised and get more training". They went on to tell us how they had recommended the home to friends.

The registered manager demonstrated a good understanding of their responsibilities as a registered manager. For example we saw the services inspection rating certificate prominently displayed in the reception area, as required by law. Before the inspection the provider had submitted a Provider Information return (PIR) to tell us about the service and the improvements they planned to make. We saw the home manager was making progress with their proposals to develop the service. For example, they had implemented a satisfaction survey. They were also meeting their legal obligations relating to submission of notifications to CQC when certain events occurred, such as serious injuries or allegations of abuse. Staff performance and conduct was monitored and appropriate procedures were in place and utilised if necessary. For example, disciplinary procedures.

Staff understood their roles and responsibilities and there were good communication systems within the home to enable them to provide effective care for people. Staff told us they felt well supported by the home manager and other senior members of staff and told us they were happy in their roles. One staff member said, "I am supported in my role, both the home manager and the deputy manager are approachable. I love working here, I have worked in a lot of places. This is the best".

The provider had systems and processes in place to enable people, their relatives and staff to give feedback on the service provided. One person we spoke with told us how they were consulted with on the decoration of the home. They told us they were confident their views would be taken into consideration. They said, "They would listen if it was a serious consideration". Another person told us how they were asked what activities they would like to engage in. Relatives we spoke told us they were able to provide feedback informally through discussions with staff or the home manager or during care reviews. We also saw the home manager had introduced a satisfaction survey for people and their relatives to complete. We reviewed some of the completed questionnaires and saw positive feedback had been provided. We also saw where suggestions had been made, these had been actioned. For example, a suggestion to display the daily

activities on a notice board was now being completed. Staff told us they felt they were encouraged to be involved in the development of the home. A staff member said, "We have staff meetings every month, I feel confident in saying what I feel. We are encouraged to be involved in the running of the home". Two staff members we spoke with went on to tell us about suggestions they had put forward that had been implemented. This showed the provider had systems in place to encourage feedback and information was being used to make improvements.

There were systems in place to check the quality and consistency of the service provided. A range of audits and checks were being regularly completed. For example, medications checks and checks of staff competency. Audits and checks were effective at identifying required improvements. Where improvements were identified appropriate action was taken. For example, we saw medication checks had identified concerns relating to the recording of medication administrations. We saw medications checks had identified this concern ad in response staff had received further training and support. Records we looked at showed an improvement in medicines recording practices and a reduction in recording errors. The provider had systems in place to identify and manage risks to the safety and welfare of the people living at the home. Accidents and incidents were being monitored and analysed regularly to identify patterns and trends. This information was being used to ensure appropriate action was taken to keep people safe. For example we saw the home manager had noticed an increased number of people with cold like symptoms and had escalated these concerns to the infection prevention and control team who visited the home during the inspection to provide advice and guidance to the home manager.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider was not appropriately applying the principles of the Mental Capacity Act.