Care Quality Commission

Oak Care Limited

Oak Tree Manor

Inspection report

1-2 Chene Drive
Waverley Road
St Albans
Hertfordshire
AL3 5 QP
Tel: 01727 832393
Website:oak.care@virgin.net

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Ratings

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

Overall summary

We carried out this unannounced inspection on the 29 and 30 October 2014. At our last inspection in July 2014 we told the provider to make improvements in how they offer formal supervision to staff. This action had been completed.

Oak Tree Manor provides care for up to 80 people some of whom may be living with dementia. The home has two floors and the people who are living with dementia are cared for on the top floor. At the time of the inspection there were 76 people living in the home.

The service has 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.

Summary of findings

The provider had effective recruitment processes in place, and there were sufficient staff employed. They received formal supervision however they were not deployed and managed effectively on a day to day basis.

People's needs were assessed, however care plans did not take account of people's individual needs and wishes and choices and they were not supported to pursue their interests and hobbies.

Medicines were not managed safely. There were risk assessments in place, however they did not contain sufficient detail to keep people safe at all times. There were systems in place to safeguard people from the risk of abuse.

The staff lacked effective training in caring for people who were living with dementia. The manager understood her role in relation to Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) however most of the staff did not fully understand their role in this.

People were not supported to have sufficient food and drinks in a manner that reflected their needs and abilities.

People were supported to access other health and social care professionals when required. They were also enabled to maintain close relationships with their family members and friends.

The provider had a formal process for handling complaints and concerns but people did not feel empowered to use it.

During this inspection we found the service to be in breach of several of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the provider to take at the back of the full version of the report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was not always safe

The staff were not deployed effectively so that people received the support they needed in a timely way.

Medicines were not managed safely.

Staff were recruited safely and understood their responsibilities to report concerns to keep people safe.

Requires Improvement

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

The staff did not always understand their role in relation to the requirements of the Mental Capacity Act 2005 and the associated Deprivation of Liberty Safeguards.

People were not always supported to have enough and nutritious food and drink.

They were assisted to access other health and social care services when required.

Requires Improvement

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

Staff did not always show kindness and compassion.

People's privacy and dignity was not always respected and they did not always have choice and control over their lives.

Requires Improvement

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

People's individual needs had not always been assessed and care plans lacked clear direction to staff. People were not supported to follow their interests or hobbies.

Complaints policy was in place but not always used by the people because they feared a negative response from the provider.

Requires Improvement

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

Quality monitoring audits were not always used effectively to drive improvements.

Requires Improvement

Summary of findings

People who used the service and their relatives were not enabled to routinely share their experiences of the service.

The culture of the home was not open and inclusive.

Oak Tree Manor

Detailed findings

Background to this inspection

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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 was carried out on 29 and 30 October 2014. The inspection was unannounced. The inspection was undertaken by 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 care service. Their area of experience was caring for people who are living with dementia.

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 improvements they plan to make.

We reviewed other information that we held about the service such as notifications. A notification is information about important events which the provider is required to send us by law. We also reviewed any information that had been sent to us by other agencies about this service.

During the inspection we spoke with 12 people who lived at the home, five relatives, six care staff and two domestic staff, the manager and the provider. We also observed how care and support was provided to people. 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.

We looked at seven people's care plan records, three staff files that showed how staff were recruited and training records for all the staff. We also looked at records related to the running of the home and the quality of the service. This included audits and information relating to the maintenance of the home, safety and fire records, staff duty rotas, monthly service newsletters, team meeting records, complaints and compliments information, and quality surveys undertaken by the provider.

We also contacted two health care professionals, who had attended the home to work with people who lived there, to obtain their views on the service.

Requires Improvement

Is the service safe?

Our findings

We found medicines were not administered and recorded in a manner that ensured that people had been given their medicines safely or as prescribed. Medication Administration Records (MAR) were not consistently completed to show that people had been given their medicines. There were a number of gaps where a person's eye drops should have been signed for, and we noted that a staff member had signed the MAR in advance of giving another person their medication. We discussed this with the staff concerned and they showed no concern about the discrepancies we pointed out or how this could put people at risk.

At 11:20am, we noted that a person's medicine that had been prescribed to be given at 5pm had already been dispensed into an unlabelled medicine pot and left in the medicine trolley. We were told that this was done to assist the staff who were very busy. This was an unsafe practice where staff could not be sure of what medicine they were administering or who it was for. Pain relief was not always administered as prescribed, and we saw that this left a person in pain and distressed.

Another MAR had been signed by staff before the person was offered their medicine. When it was offered we noted that they refused it, however no changes were made to the records. We asked why the staff had not recorded this refusal as it happened and they told us, "Someone [staff] will try later."

We observed that staff were rushed in administering medication. One person was offered a tablet that was too big for them to swallow. We heard them say, "This tablet is too big I will choke on it." They asked the staff to break it in half for them. This was done by the staff member, however they did not consider whether breaking the tablet would affect the release of the medication, or take any action to find out if the medication could be obtained in smaller tablets or a liquid form to make it easier for the person to swallow

On the day of the inspection a staff member who was working a long day (two shifts), had signed the MAR in the morning for medicine that was not due to be administered until the evening. We asked staff why this happened we were told, "This is common practice, I don't know why you think it's a problem. We [staff] all trust each other." We also saw that a senior member of staff had signed at 11.30 am for a medicine check that was due to be done at 8pm.

Controlled drugs were not always appropriately signed for when they were given to people.

We saw that a controlled drug that had been administered on the 28 October 2014, had been recorded on the MAR chart but not recorded in the controlled drugs book as required.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Most people we spoke with on the ground floor of the home told us that they felt safe and had their freedom promoted. They said, "of course I feel safe." And, "there is always someone around at night which is nice and makes it feel safe."

Staff had received training in how to keep people safe from abuse. They were able to tell us what safeguarding meant in theory, the sort of things they would report and who they would report their concerns to. The registered manager understood her responsibilities to keep people safe and our records showed that she reported incidents appropriately to the Care Quality Commission (CQC) and to the Local Authority.

People did not have individual risk assessments in place and risk had not been identified or managed appropriately. We observed the use of deep chairs that people were unable to get in and out of independently. We were told that these were used to reduce the risk of people falling. However not all of the people using them had risk assessments in place that detailed why the chairs were needed and how staff should use the chairs to promote the balance between safety and independence was acknowledged and managed. We found bed sides were used to keep people safe at night; however there were no detailed risk assessments in place to show that these were being used appropriately. We did not see any evidence that people had been involved in identifying risk to themselves or how they would like the risk to be reduced.

People's falls were monitored and where possible actions were implemented to promote the safety of the person. The home had procedures in place so that in the event of an emergency, such as fire, evacuating the home was

Requires Improvement

Is the service safe?

carried out safely. There was a maintenance plan in place to ensure the building and surrounding premises provided a safe home for those who lived there. The garden had been made safe for people who had poor mobility. This was done through the use of smooth pathways and seats situated at short intervals apart to enable people to stop and rest when they needed to.

The manager told us that she did not have a recognised tool to assess the number of staff needed to meet people's needs. Although there were sufficient numbers of staff on duty, we found they did not all have the right skills and experience to support the people they were allocated to care for. For example the member of staff that was most skilled in caring for people who were living with dementia was not allocated to work in the area of the home that accommodated people with these particular needs. None of the staff we observed demonstrated that they had the necessary skills to care for people with dementia, and as a result people were left isolated, and their attempts to communicate with staff were not recognised or responded to. For example we saw one person who was left on their own in the dining room for up to two hours, when we asked staff why, we were told that they 'lashed out' and staff were nervous of approaching them.

Discussions with staff and a review of recruitment records showed that the provider had robust processes in place to check the employment history and identity of staff they intended to employ. This included references and a satisfactory Disclosure and Barring Service (DBS) check. The staff we spoke with told us that they were not allowed to work until all the pre-employment checks had been completed and their documentation was in place.

Requires Improvement

Is the service effective?

Our findings

At our last inspection in July 2014, we found the home was in breach of Regulation 23 because staff were not receiving support and supervision on a regular basis. Discussions with staff and a review of records showed that this matter had been addressed and the staff now received the appropriate level of support and regular supervision. Staff said, "I feel well supported, I love caring for older people. I am happy working here." Another said, "Our manager is very approachable and I would have no concerns about raising any issues."

Staff were provided with a range of training, however we found many still lacked the skills to deliver effective care safely. For example, although staff had completed moving and handling training, we saw that people were assisted to move in a manner that could have put them at risk. People were lifted from the floor without seeking their consent and without the use of a hoist. We also saw that people were assisted up from chairs by staff lifting them under their arms. Both of these methods of lifting presented risks of injury to all the individuals concerned. When we asked staff about this they hadn't considered the possible risk of injuries and said that these people were easy to lift.

We also noted from our discussions with staff and our observations of care delivery, that they had not had the training to equip them with the skills to care for people who were living with dementia. Although they had received some training, this was not effective in delivering appropriate care that was tailored to meet individual needs. We saw that people's basic physical needs had been met and they looked well cared for. However staff lacked the skills to communicate with people in a manner they understood. As a consequence we found that most of the people who lived with dementia were left without staffing input that focused on their emotional well-being as well as meeting their physical needs.

Although records showed that most of the staff had completed training in the Mental Capacity Act (MCA) and the associated Deprivation of Liberty Safeguards (DoLS). Discussions with staff showed that they did not have a full understanding of this subject or how it was applied in practice.

This was a breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The manager understood her responsibilities to the people under the Mental Capacity Act 2005 (MCA). We saw that one person had an authorisation in place in accordance with the Deprivation of Liberty Safeguards (DoLS). A further 59 applications had been submitted and the provider was waiting for a response from the local authority.

We saw that staff did not routinely get people's consent before delivering care. On one occasion we saw that staff attempted to move a person who was asleep from their chair to a wheel chair without any communication. The person woke up and we saw that they were upset and confused. On another occasion, staff failed to seek a person's consent before they were moved into a wheel chair and taken out of the room

We observed the lunch time service and noted that most people were seated for up to 30 minutes before the meal was served. This did not suit a number of people who either did not want to, or through their illness were unable to sit for prolonged periods. We saw that some people did not understand what they were waiting for and had started to get upset and agitated. We also saw that some people were not given food and drink in a manner that suited them and their ability to eat.

We received positive comments from some people about the food such as, "The vegetables are always nicely cooked." And one person told us that they, "Look forward to lunch." However we noted that if people did not eat what they were given, they were not offered an alternative dish. A choice in how to eat was not encouraged or considered, for example we saw that some people had lost the ability to use a knife and fork, but could have managed finger foods independently had they been offered. We could not find any detail in these peoples care plans about their preferences for food and drink or the most effective way to enable them to maintain their independence at meal times.

Although there was no recognised tool to assess people nutritional needs, staff told us that when people lost weight, their food and fluid intake was monitored and recorded on a chart. We looked at the care plans of three people who were having their dietary intake recorded, and found that these had been appropriately completed.

The provider worked with various health and social care professionals to ensure that people's ongoing health needs were managed appropriately. People told us that they had

Requires Improvement

Is the service effective?

access to health and social care professionals such as GP's, opticians, nursing professionals and dentists. They said that they did not have to wait too long for a GP visit. Health care professionals we spoke with told us that their directions were always followed by the staff who worked well in the best interest of the people using the service. They said that they visit the home on a regular basis and found that the people were generally well cared for. We saw that people had access to health care professionals such as opticians and dentist.

Requires Improvement

Is the service caring?

Our findings

People in the home were cared for on two floors. The people who lived on the ground floor who were able to communicate with us and they told us that the staff were very kind and caring. Some of the people said, "All the girls are different but all very considerate." "They know what I like and make sure it happens." "They are very kind." Visitors to the home told us that they were happy with the care and that the staff were kind and caring.

However we observed people on the top floor who were living with dementia and did not have verbal communication skills, did not receive the same level of care and consideration. Staff struggled to recognise and meet their needs, promote their dignity or assist them to make their own decisions. We saw that they were spoken to and assisted to move in a childlike manner. For example when staff assisted people to walk they outpaced them and held their hand, instead of letting the person set the pace and walking by the person's side. This would have allowed the person to chat and walk at their own pace. It took one person up to four minutes to recover their breath once they were sitting down. People were not always listened to and staff dismissed or missed their attempts to communicate. For example we saw one person continually express their pain and ask for pain relief. They were ignored, and when we asked staff to attend to this person we were told that they were always asking for something. We saw another person ask to be taken to the toilet and they were told that it was not time yet. This response reduced the control the person had over their own life and detracted from their dignity and choice as an individual.

We saw that staff did not always demonstrate a caring approach because they were focused on tasks rather than on the people they were caring for. For example, staff were completing paperwork in an area of the home where they could not observe people. Those people who did not have good communication skills or good mobility could not attract the staff's attention and therefore got ignored. As the staff were focused on the paperwork, they missed the small signals that people were able to make to show they needed assistance.

During our observations various members of staff entered the sitting room and did not speak to people as they passed them by. They did not smile or any make any eye contact with them. One person smiled and spoke to a member of staff, however the staff member did not see or hear them and left the room without any acknowledgement. We later looked at the individual's care plan and saw that they rarely spoke. Staff had missed this opportunity to engage with them. Another person asked for the 'box of chocolates' that was on the table. Staff handed it to them, however it was a jigsaw puzzle and not chocolates. The person said that it's 'just a load of rubbish.' But the staff had left by then and was therefore unaware of the negative effects this had on the person as they were left looking sad and disappointed.

There was a lack of kindness and compassion demonstrated by staff when caring for people who were living with a dementia. During an activity session, we heard staff reprimanding a person in a child-like manner. They said, "could you be quiet, the others want to listen". The same person was then told, "your language is inappropriate if you don't stop, I am going to get the girls (care staff) to take you to your bedroom." Because of their dementia the person did not understand what was expected of them. The staff member did not recognise the negative impact this had on the person.

We saw that the people who were living with dementia were not shown respect as individuals and supported to make choices. They did not have free access to the garden or to fresh air when they wanted it. Although staff told us that they took the people out when they had spare time, but were unable to say when the last time was. When people tried to leave an organised activity session, they were told to sit down in a disrespectful manner. The doors were closed and were difficult to open, which meant that most people could not leave when they wanted to. People were cared for in a manner that did not respect people's dignity or promote their independence.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

In contrast to our observations in the area which accommodated people with dementia, we found that people on the ground floor were supported to be independent. People had been encouraged to complete a range of activities of daily living, including domestic tasks. They told us that they were asked for their views and their wishes were respected by staff. People's dignity in delivering personal care was promoted and we saw that staff knocked on people's doors before entering.

Requires Improvement

Is the service responsive?

Our findings

People who lived on the ground floor of the home told us that they had to wait too long for assistance. One person told us, "The most frequent word used is wait." We were told that small changes could make people's life more enjoyable. This included staff showing people that they were being listened to. Another person said that due to pressure of work it took staff so long to respond to their requests for assistance, they had lost confidence in having immediate needs, such as going to the toilet, met when they needed it. This meant that they had stopped moving about the home and now stayed in their room close to facilities. Furthermore they had also stopped attending activities and going to the dining room for meals. This was not their wish and resulted in them being isolated and lonely.

We saw that people were shivering and had told staff that they were cold. Nothing had been done to make people more comfortable. During our observation, a staff member opened a window. Two people said they were cold, the staff member asked a third person if they were cold. When this person did not answer, the staff member took this as a positive response and left the window open and people continued to show signs of being cold. We saw another person left alone and cold in the dining room with all the windows open. We asked the manager to look at this and while we were there she checked the temperatures, offered extra bedding to people and ensured that the windows were closed.

People were not always involved in the planning or review of their care. There was no evidence of individualised or personalised information that staff who cared for people living with dementia could use. Although some people's likes and dislikes were recorded, staff we spoke with were unaware of them. The home used tick sheets to assess people's needs in relation to mobility, continence and nutrition. People's individual needs in relation to their health, mental welfare and conditions were not explored and therefore not documented or available to staff to assist them in delivering care. We found what was called a 'toilet book', which listed each person and when they had their bowels opened, received a shower and/or bath and had their nails trimmed. We could find no reference to preference or choice detailed in this folder or any of the care plans we looked at. We saw a 'daily and nightly choices' section in the care plans but these were a list of tasks required and not any individualised lifestyle choices.

People were referred to as being 'resistant' to the care the staff offered, instead of staff responding to the people's needs. An example of this we observed was when one person was taken to the toilet. This was not offered as an option but it was time for people to be 'toileted'. Staff told us that two people were needed to assist this person as they resisted staff's assistance. There was no consideration given to the person's wishes or personal needs at this time.

We observed that some staff did not communicate with people in a way they could understand. They showed no understanding of the needs of a person who showed signs of distress. This was ignored by staff in the room until we asked for them to attend to the person. We were told that they were always like that and to take no notice. We asked three different care staff if they could attend to the person before one attended to them.

People who were able to express their needs were not supported to pursue individual interests or hobbies. One person said, "I used to knit and would like to again, I don't know why it had stopped." They said that they had stopped going to organised activities as they said that the activities didn't suit them. We observed one activity period held in the upstairs lounge. We observed for almost an hour and saw that only two or three of the 17 people present showed any signs of interest in what was going on. This lack of interest was not acknowledged by staff. We saw that notes were made in the 'daily notes' of the individual people that they had taken part in the activity. This implied people had enjoyed and been happy with the activities provided and prevented more choices from being offered to people.

We found that care was not delivered in a manner that recognised the person's individuality. There was a marked difference in the care of people who were living with dementia in the home to those in the rest of the home. The diversity of their situation was not respected and their care was delivered in a manner that did not recognise their complex needs and the requirements for more skilled support. Care plans were ineffective in assisting staff to care for the people. The effects of a person's dementia was

Requires Improvement

Is the service responsive?

not documented therefore staff did not know how best to care for them and had cared for them in a task orientated manner that excluded their wishes, aspirations and interests.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People were encouraged to maintain contact with family and friends. There were no restrictions on visiting. People's relatives told us that they were welcomed at all times into the home.

The manager told us that they welcomed complaints and people knew how to use the complaints process. However the relatives we spoke with told us that they did not have confidence in using it as they felt that their relative might be punished for them making a complaint. Therefore they were reluctant to feedback on anything that might be conceived as negative. One person told us that the process of complaining was not easy. People had been advised to complain to the person in the office and care staff were not permitted to listen to people's complaints. They said they did not know why this was, but they felt that it might be in place to prevent complaints being made. Despite these comments we saw that some people had made complaints, the most recent was in September 2014. This had been fully investigated and records maintained to demonstrate that the process had been followed and a satisfactory conclusion reached for the complainant.

Requires Improvement

Is the service well-led?

Our findings

People told us that they thought the culture of the home was 'closed.' This was because they were not encouraged to be involved in care planning and were not encouraged to have open conversation about the home where they could express their views.

The people who used the service and their representative were not included in the development of the service. Because of this lack of inclusion the home had no verifiable way of knowing whether they were meeting the needs and wishes of the person. This was evidenced throughout the inspection as people's basic physical needs were met, but their emotional needs were not recognised or met. The stimulation offered did not suit most people throughout the home and they told us that they were not supported to pursue their personal interests and hobbies. Activity staff decided what activities would take place and people were just expected to attend, although it was clear that very few were interested in what was happening.

The provider had failed to ensure that people who were living with dementia were empowered to be as independent as possible. Their care was task led and people were expected to fit into the home's regimes rather than the home fit with the person's needs and wishes. For example people were expected to fit into how the provider served meals or the allocated times for going to the toilet.

The provider had quality monitoring system in place and various audits had been completed, however these were not effective. They had failed to identify the shortfalls in staff training and the skill mix and allocation of staff on duty was not done in the best interests of the people who lived in the home. Medication audits had failed to identify the errors and poor practices identified in this inspection. Risk was not always identifies as audits had failed to recognise that people were put at risk through poor moving and handling techniques.

This is a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Staff told us that they were happy in the home and that their motivation was high. All of the staff we spoke with told us that they were well supported by the manager. However we found that staff showed a lack of respect for other levels of management in the home and failed to show any accountability for their own performance and behaviours. For example we saw staff go on breaks without any discussion with the shift leader or ensuring the people were safe. Senior staff did not have the confidence to question this behaviour and therefore it went unquestioned.

The provider spent time in the home and worked closely with the registered manager to identify areas for improvement. However this was not effective as the people's individual needs in relation to their care and welfare of the people was not always promoted.

The home had a whistle blowing policy in place, which staff were aware of, understood and knew how to use.

People's records were stored securely to prevent unauthorised access to them

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 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 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services **People who use services were not protected against the risks associated with not having a process in place to ensure they have their care delivered in a manner that recognised their individual needs and risks.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers **People who use services were not protected against the risks associated with not having a robust system in place that assess and monitors the delivery of the service**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines **People who use services were not protected against the risks associated with the unsafe administration of medication.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010 Respecting and involving people who use services **People who used the service did not have their care delivered in a manner that promoted their dignity.**

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing People who use services were not protected against the risks associated with not having trained staff to meet the needs of the people.