

Bupa Care Homes (CFHCare) Limited

Oak Lodge Nursing Home

Inspection report

45 Freemantle Common Road,
Southampton
SO19 7NG

Tel: 023 80 425560

Website: www.legalcareservices@bupa.com

Date of inspection visit: 20 and 22 October 2015

Date of publication: 31/12/2015

Ratings

Overall rating for this service

Good 

Is the service safe?

Good 

Is the service effective?

Good 

Is the service caring?

Good 

Is the service responsive?

Good 

Is the service well-led?

Good 

Overall summary

We inspected Oak Lodge Nursing Home on 20 and 22 October 2015 and this inspection was unannounced. Oak Lodge Nursing Home is registered to provide accommodation and personal care for up to 71 people. At the time of the inspection there were 57 people using the service. The service was over four floors, and each floor was defined by the level of care required by each person.

There was a new manager in post who was waiting for was in the process of becoming registered with CQC. 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. There was also a deputy manager in post, as well as 13 registered nurses and 59 care staff. There were two maintenance workers, two administration staff, a head housekeeper and housekeeping staff, a head chef as well as other kitchen staff.

The people were well cared for and there were enough staff to support them effectively. The staff were knowledgeable about the individual needs of the people and knew how to spot signs of abuse. People's relatives

Summary of findings

said they felt their loved ones were safe and supported by the care staff and the manager. The manager followed safe processes to check the staff they employed were suitable to work with vulnerable people. Medicines were managed safely and people received their medicines as prescribed.

Care records and risk assessments were person-centred, up to date and were an accurate reflection of the person's care and support needs. The care plans were written with the person, so they were fully involved in the planning and identifying of their support needs. The care plans included the person's likes and preferences and were reviewed regularly to reflect changes to the person's needs.

Staff received regular supervision and had completed training appropriate to their role. The service had ensured that all required checks had been completed prior to the staff being employed.

People's relatives said the manager and staff were caring. They spoke to people in a kind, respectful and caring manner. There was an open, trusting relationship between them, which showed that the staff and provider knew the people well. We observed staff supporting people with respect whilst assisting them to maintain their independence.

Staff said they worked well as a team, and the manager provided support and guidance as they needed it. There was an open and transparent culture which was promoted amongst the staff. This allowed them to learn from incidents and changes were made to the service following feedback from people, their relatives and staff.

The manager demonstrated a good understanding of the importance of effective quality assurance systems. There was a process in place to monitor quality and to understand the experiences of the people who used the service. The manager had a desire to learn and implement best practice throughout the service.

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 safe.

People were protected from the risk of abuse. Risks to people's health and well-being were managed effectively.

People's medicines were managed safely.

There were enough staff to meet people's needs and recruiting practices ensured that all appropriate checks had been completed.

Good



Is the service effective?

The service was effective.

The service ensure people received effective care that met their needs and wishes.

Staff completed training appropriate to their role and were supported through supervisions.

Both management and care staff understood their responsibilities in relation to the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS).

People's nutritional needs were met. They had access to health professionals and other specialists if they needed them.

Good



Is the service caring?

The service was caring.

People and staff had a positive relationship. People's privacy was protected, their dignity respected and they were supported to maintain their independence.

People experienced care that was caring and compassionate.

Good



Is the service responsive?

The service was responsive.

People's needs were reviewed regularly. Care plans reflected the individual's needs and how these should be met. Their choices and preferences were respected.

People's relatives knew how to complain and said they would raise issues if the need arose. Complaints had been responded to appropriately and in a timely manner.

Good



Is the service well-led?

The service was well-led.

People's relatives and staff reported that the service was well led and was open about the decisions and actions taken.

Quality audits were in place to monitor and ensure the on-going quality and safety of the service.

Good



Oak Lodge Nursing Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection 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 20 and 22 October 2015 and was unannounced.

The inspection team consisted of an inspector and a specialist advisor in dementia nursing care.

Due to the level of the people's dementia, we spoke with three people living at the home and observed people in the

main communal areas, to understand the experiences of the people we were unable to verbally communicate with. We also spoke with four relatives, the manager, the deputy manager, four nurses and 10 members of staff. We looked at 10 care plans and associated records, along with records relating to the management of the service. We also looked at staff recruitment files as well as their training records. We observed interactions between the manager, staff and the people within the home environment. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of the people who could not talk to us.

At our last inspection in September 2014, no concerns were identified.

Is the service safe?

Our findings

Everyone we spoke with said they felt the people using the service were safe. Relatives of one person said that they were “happy with the care so far, and I have no reason to believe [their relative] is not safe”. Another relative said that a few months ago if that question had been asked, they would have said “no”, however since the new manager had come into post, things were different and they believed their relative was now safe. They explained “I can come and knock the door; if anything wants doing [the manager] will do it. There wasn’t enough staff in the communal lounges and they were using a lot of agency staff, so there was no continuity. This has all changed with the new manager”.

There were appropriate policies in place to protect people from abuse. Staff had received training in safeguarding adults and were aware of the different types of abuse. They were able to explain what actions they would take if they had any concerns and described the process, procedures and actions they would take if they didn’t feel appropriate action had been taken. All care staff spoken with knew how to contact the local safeguarding adult’s team. Staff felt confident that they could raise their concerns with the manager.

Risks were managed safely. All care plans viewed contained personalised risk assessments, which gave details about the risks posed to that individual. These included the risk of people choking, falling (including having bed rails), moving and handling and risks to a person’s skin integrity. Risk assessments were reviewed regularly so that any new risks could be identified in a timely manner and an assessment completed as required. Where people required support with moving and handling, staff had been trained to support people to move safely using equipment such as hoists. Risk assessments were in place to ensure the people maintained their independence whilst doing so safely. For example, one person who was prone to falls had a pressure mat put down in front of her chair, when seated in the communal lounge. This ensured the staff were notified if this person tried to mobilise without their support, and could get to the person to offer support.

There were plans in place to manage environmental risks such as fire, and staff knew what to do to keep people safe in an emergency. The home had keypad coded doors, which were secure at all times. There were appropriate assessments in place for the use of the coded doors, which

was in line with legislation. They were used to ensure the safety of the people using the service. Records of maintenance checks had been completed by both internal staff and external contractors.

Nurses and care staff were together for handover and were given information about the health and wellbeing of each person and any changes were noted. Each team member had their own pre-printed sheet for each person which included their medical conditions and any specific care risks for example; choking, moving and handling and falls risks. A record of the handover was kept in a file at the nurse’s station. During handover the deployment of staff was agreed between the nurse and senior care staff to ensure fair distribution of staff support to meet identified needs. Care staff then reported back to the nurse in charge throughout the day, reporting any changes or concerns as identified. By updating all the staff about the current wellbeing of the people and identifying any potential risks actions could be taken to prevent incidents occurring and minimise the risk to people and staff.

There was a robust recruitment process which helped ensure staff were suitable to work with people who lived at the home. Prior to commencing employment staff had undergone a check with the Disclosure and Barring Service [DBS] and had references from previous employers. The DBS helps employers make safer recruitment decisions and prevent unsuitable people from working with vulnerable groups. Application forms showed staff had previous experience within a caring role as well as a full employment history.

Systems were in place to ensure adequate numbers of staff were employed. The manager explained they had increased care staff numbers to meet physical and emotional/psychological dependencies of people. Care staff acknowledged this increase in staff gave them more time to spend with people.

People were supported to receive their medicines safely. All medicines were stored safely and appropriate arrangements were in place for obtaining, recording, administering and disposing of prescribed medicines. Nursing staff administered all medicines apart from topical creams, and had been assessed as competent to administer medicines. Topical creams were administered by all care staff and there were appropriate care plans in place to support this. These gave clear descriptions of which cream was to be used, when and where it had been

Is the service safe?

used. There were protocols in place for people who required their medicines to be given covertly. They were

also in place where people had been prescribed as required medicines (PRN). Where people were able to self-administer, the provider's policy ensured this had been risk assessed to ensure people had the capacity to do this.

Is the service effective?

Our findings

People spoke highly of the manager and the staff. A relative said “I can go to them about anything, and it gets done”. The staff spoke warmly of the people they cared for and were able to explain people’s care needs and their likes and dislikes.

All staff had undertaken essential training in areas such as Dementia, Safeguarding, Mental Capacity Act, and Medicines, as well as further training in specific areas. New staff completed a two week induction to the service. During this time, the manager would ensure that the care staff worked on each of the four floors in the service. Once their induction was complete, they were allocated to the floor where their skills were best matched to the resident group and the current team’s skill mix. This meant the care staff got to know the people they were working with, and were able to build trusting relationships with them. This was especially important for people with short term memory loss. By using staff with the right skills matched to the resident group demonstrated best practice and was reflected consistently by the care team’s knowledge of the people. We saw high levels of interaction and engagement between people and staff.

Staff showed a good understanding of the needs of people who lived with dementia. They knew how to adapt the care to meet the changes in their dementia as it occurred. Staff were seen making visual contact with the person first, before following this by touch and then speaking to them. On occasion this was done a little too quickly, which may prevent the person from having time to acknowledge and process the information or actions. However, staff showed a willingness to take this on board, and slow the process down.

The manager was one of Bupa’s Dementia Ambassadors. They worked closely with the Admiral nurses and other ambassadors to improve the quality of care and support for people living with dementia. Currently the head housekeeper was the champion for dementia and had an active role about mentoring staff and demonstrating best practice to improve engagement interaction.

Staff received regular supervisions and an annual appraisal. Supervisions provide an opportunity for management to meet with staff, feedback on their performance, identify any concerns, offer support,

assurances and learning opportunities to help them develop. Records of supervisions showed a formal system was used to ensure all relevant topics were discussed. Where actions were identified the process ensured these were reviewed at the subsequent supervision meetings. Staff said they were able to approach the manager outside of the scheduled supervision if they needed to discuss anything.

People’s consent to care and treatment was sought in line with legislation. Staff were observed asking for the person’s consent prior to providing any support. There was consent documentation within all the reviewed care files and staff had a good understanding of the need for, and the use of mental capacity assessments. Where possible, the people had given their consent. The manager followed the Mental Capacity Act 2005 (MCA) and staff had a good understanding of this. The MCA is a legal framework to assess people’s capacity to make certain decisions, at certain times. When people are assessed as not having the capacity to make a certain decision, then a best interest decision needs to be made for them. A best interest decision should be made involving those people who know the person well, including other professionals when relevant. In records we viewed, there was evidence of appropriate best interest decisions having been made.

The manager had appropriate policies in place in relation to Deprivation of Liberty Safeguards (DoLS). DoLS provides a process by which a person can be deprived of their liberty when they do not have the capacity to make a certain decision and there is no other way to look after the person. These safeguards protect the rights of the people using the services by ensuring if there are any restrictions to their freedom and liberty, these have been authorised by the local authority as being required to protect people from harm. There were restrictive practices being used within the service and staff were clear in their understanding of DoLS in relation to the use of keypads to secure each floor of the service. Where necessary applications had been made to the local authority for assessment under the DoLS legislation.

People and relatives said the food was excellent. They were offered varied and nutritional meals which were freshly prepared in the home prior to being served. Alternatives were always offered and there were pictorial examples of each meal on offer. However, we did not see these being used. Instead we saw staff showing the people plates of the

Is the service effective?

meals and allowing the people time to choose. Drinks were available throughout the day and staff prompted people to drink often. People were encouraged to eat and staff provided appropriate support. For example when one person was given their meal it was presented on a plate with a plate guard, and it appeared to have been cut up before being served. This person then sat waiting to start their meal, the staff member returned with a meal for another person in the lounge and noticed that this person hadn't begun to eat. They supported the person to put some food on their fork. This action enabled the person to eat the rest of their meal without support.

Some people were encouraged to eat in the dining rooms, but others chose to remain in the lounge or their bedrooms. The cook recognised that people were not eating together, so once a month, each floor had a tea party, to which relatives were invited. The lounge was set up with a finger buffet for all the people and their relatives to attend. This proved to be a popular event, and some

people who wouldn't normally eat very much were encouraged to eat more in these social occasions. The catering staff were aware of people's special dietary needs and described how they would meet these. Staff monitored the food and fluid intakes of people at risk of malnutrition or dehydration. Records were kept up to date, and any concerns identified were acted on. They monitored the weight of people monthly, unless there was a concern.

People were able to access healthcare services when required. Relatives told us their family members always saw the GP when required. One relative said that previously they had to ask for the GP themselves, but now the new manager is in post things have "drastically improved". One person had difficulties swallowing and was assessed as high risk of choking; the service involved the Speech and Language Therapist (SaLT) who recommended actions to be taken. The GP visited the service every Monday and Friday, they were also supported by a nurse practitioner.

Is the service caring?

Our findings

Everyone we spoke with said the staff and manager were very caring. One relative said “there are some lovely carers, the manager is lovely”, another relative said “my [the person] is well cared for, and always clean”. Another said “generally they [staff] are all caring, and the nurses are superb”.

We observed caring interactions between the people, their relatives, care staff and other professionals. Staff had time to sit with people and talk to them rather than being task orientated. They knew the people they were caring for and this was shown by how they responded when people became upset and anxious. Staff would support and calm them by offering other activities or moving them to another room. Staff were able to do this using their understanding of the people through the information shared in their care plans and also how their dementia may be affecting them.

People and their relatives were involved in developing their care plans. The care plans contained information about the person’s abilities, what they could do for themselves and what support they needed. For those people who remained in their rooms, their care plans were kept in the room. This

enabled staff to complete them as they went along and relatives could see if any changes had occurred. For those who were spending the day in the communal areas, their care plans were kept securely in a closed cabinet.

Staff we spoke with appeared to be proud of the service and passionate about the people they provided care and support for. They treated everyone with dignity and ensured doors were closed when personal care was being provided. Staff would always knock on bedroom doors before entering. We observed interactions between staff and people to be consistently respectful. Staff got down to the person’s level to communicate with them. Staff spoke with each other in a compassionate and respectful way.

The home had close links with the palliative care nurses from the local hospice and were following the ‘six steps’ end of life care programme. The aim of this was to provide person centred care, to people nearing the end of their lives. There was evidence of advance care planning and end of life wishes, documented in the people’s care plans. One person had been supported by the advocacy service to make arrangements for their funeral. Do not attempt cardio pulmonary resuscitation [DNACPR] forms involved the person where appropriate and had been reviewed when necessary.

Is the service responsive?

Our findings

People received individualised care which met their needs. Their care plans were detailed and informative. They included information about the person and their likes and dislikes. People's relatives said they were satisfied with the care and they told us how involved they were in writing the individualised plans. By involving relatives, the service were able to build a picture about the person, their needs and how they would want to be supported. The care plans were updated regularly to ensure that the information was accurate and a true reflection of the person's current needs. They provided clear guidance to staff about the person, and provided them with clear instructions on how to manage specific situations.

Staff knew what person-centred care meant and could relate how they provided it. They knew people's likes and dislikes and were knowledgeable about people's individual needs and how to ensure these needs were met. Staff explained that people were given the opportunity to make choices about their care enabling them to be involved in decision making. For example; during personal care, people were given choices about clothing and were shown two options, and staff would then wait for the person to make their choice. People's life stories were recorded in their care files. This highlighted key life events and experiences the person had. One person liked to sing, so it had been arranged that they would attend an external singing group twice a month.

The manager had extensive knowledge and understanding of working with people who were living with dementia. The manager said "My first priority [when taking over the role as manager], was for all staff within the service to complete Bupa's dementia specific training". Staff said the training had made a difference. One member of staff said "I immediately approached people differently, seeing them as a person rather than their dementia".

The service employed two activities workers, who alongside the care staff, would endeavour to spend time with all the people who remained in their rooms for the majority of the day. The manager had identified people who could be socially isolated, and involved the staff team in improving opportunities for engagement and occupation. The service had adopted a whole home approach to activities and whilst it was "early days" activity provision, meaningful engagement and occupation were discussed by heads of department at their morning meeting.

Relatives and friends were actively encouraged to visit. There was evidence of both doll therapy [where a doll has been given to the person as a method to alleviate agitation and distress] and animal therapy being used within the service. One relative said "I visit daily; [the person] loves it when they bring the animals in to visit".

People and their relatives were given opportunities to express their views about the service. Meetings were held regularly and a recent 'resident and relative' survey had been completed. The manager used the feedback from this to identify actions required to improve the quality of the service. This had identified there wasn't any information about the Care Quality Commission (CQC) and their role within the service. The manager had addressed this by dedicating a specific wall space, where all relatives are able to access it, to information about the CQC. A complaint had been received about laundry going missing. The manager had responded to this by requesting the provider purchase a tag machine so that everyone's clothing items could be individually labelled. There was a formal complaints procedure in place, and any complaints received had been acted on appropriately and in a timely manner.

Is the service well-led?

Our findings

People's relatives felt the service was better led since the new manager started. One relative said "It's got better since the new manager has come into post; [the manager] listens and takes action". Staff told us about the changes in how they were now managed. They said there was more continuity in how they were managed, and the care of the people had improved as a result of this. One member of staff said "We can see the positive changes in the residents". Another staff member said, "There has been a massive change since the manager took over. The manager listens and is so supportive. It's a two way thing now".

The vision of the service was "to promote happier, healthier lives". The service was working towards this by involving people and their families to make suggestions about changes which can be made to improve the quality of the lives of the people living there. Everyone living at the service appeared happy, and the atmosphere was calm. Family members we spoke with confirmed this by saying they felt their loved ones were happy.

Staff were aware of their roles and responsibilities and worked together as a team. Professionals and the manager spoke about how the culture in the service had been "carer led" and the nurses within the service had been disempowered. This meant the carers had been the people making the decisions and people's care needs were not being necessarily met. The manager was working with the nurses to change this so the nurses felt empowered. This

change was reported to be improving morale within the service, which was reflected on the positive care being provided. Staff said the manager was very supportive and focused on the well-being of the people who lived at the service as well as the staff.

We observed the manager was visible throughout the service supporting the care staff. Staff felt able to go to the manager about anything and there was an open door policy. If staff had any issues they wished to discuss with the manager they could go at any time. Staff felt confident to question practice, and understood the whistleblowing process. They felt they would be supported to report any concerns. One staff member said "if concerns are raised to the management team, I am confident action will be taken and my confidentiality will be protected".

Quality assurance checks were completed monthly, by the quality assurance manager and area manager. These identified if there were any areas where improvements were needed, then action plans would be put into place. When the service had a recent diarrhoea and vomiting outbreak, all staff were assessed on their hand washing techniques in order to reduce the risk of the outbreak spreading. The manager and deputy manager also carried out regular audits to ensure best practice was being followed.

The manager was aware of their responsibilities in notifying the Care Quality Commission of any significant events, and notifications had been received from the service when incidents had occurred as required.