Four Seasons (Evedale) Limited

Oaklands

Inspection report

4 Oakland Road
Moseley
Birmingham
West Midlands
B13 9DN

Tel: 01214496662
Website: www.fshc.co.uk

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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**

Summary of findings

Overall summary

This unannounced inspection took place on the 25 and 26 May 2016. The service was last inspected in April 2015, when we identified it was not meeting three regulations. At that time people could not be confident that their complaints would be identified and responded to, that there would be adequate numbers of staff available to meet their needs, or that the systems in place to monitor the safety and quality of the service were effective. At this inspection we found that work had been undertaken to address these issues. People could now be certain their complaints would be listened to and acted upon. Further work was required to improve staffing and monitoring of the service.

Oaklands provides accommodation for a maximum of 46 older adults who have nursing care needs and who may be living with dementia. There were 22 people living at the home at the time of the inspection and one of these people was in hospital. The home was divided into two units, but people were free to use all parts of the home.

The service has a registered manager who was present throughout the inspection. 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 were not enough staff available to meet people's requests for support in a timely manner. We had identified this at our last inspection, and the registered provider's action plan had not been effective at improving this situation.

People told us they felt safe living at the service. Staff were aware of how to recognise possible signs of abuse and the need to report any concerns.

Whilst most medicines were given safely we found that there were some improvements needed to the application and recording of topical medicines, such as creams. There were systems in place to monitor medication administration.

The staff had been provided with training about the Mental Capacity Act (2005) but could not explain how they put this into practice when supporting the people living at the service. Staff received basic training to ensure they were aware about safe care and some of the people's individual needs.

Most people had their healthcare needs met and received support to maintain their nutritional and hydration needs. During our inspection we observed individual staff treating people with dignity and respect, however failing to provide people with meaningful occupation, company and autonomy showed that people were not consistently treated with respect.

People and their relatives gave us mixed feedback about the care provided. Everyone told us that staff were kind and caring and knew people well, however people told us the number of staff was not always adequate to meet people's needs well. Staff that we spoke with were enthusiastic about their role and could describe how people preferred to be supported.

There were very limited opportunities for people to join in with activities they liked, and which reduced the risk of them becoming socially isolated. People and their relatives all told us this was an area that needed improvement.

The service had ensured people maintained relationships with those who were important to them.

People living at the home and their relatives were aware of how to raise concerns and were confident that any concerns raised would be dealt with in a timely manner.

People, relatives, staff and health professionals were happy with how the service was managed. The registered manager had improved the quality monitoring of the service although this had not been entirely effective, and further work was needed.

You can see what action we told the provider to take at the back of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

People did not have access to adequate numbers of staff to ensure their safety or to meet their needs in a timely way.

People could be certain they would be given their medicines as prescribed, but further work was required to improve the management of creams.

Staff were knowledgeable about safeguarding people and knew the appropriate action to take should they have any concerns.

Is the service effective?

Requires Improvement

The service was not always effective.

People could not be certain their human and civil rights would be respected.

People had access to a wide range of health professionals. Most people's healthcare needs were well met, but not always well documented or planned.

People received support to eat and d rink enough to maintain good health.

People were supported by staff who had some knowledge of their individual needs.

Is the service caring?

Requires Improvement

The service was caring.

Staff were kind and caring in their approach. Staff knew people well.

People's privacy and dignity was respected.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People were not supported to take part in activities of their preference, or protected from the risk of social isolation.

Care was reviewed to ensure it still met people's needs.

There were systems in place to manage concerns and complaints.

Is the service well-led?

Requires Improvement

The service was not always well led.

Systems that would ensure the quality and safety of the service, and drive forward improvements were not effective.

People told us that the management team was approachable.

Oaklands

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 unannounced inspection took place on the 25 and 26 May 2016. On day one the inspection team comprised of two inspector's. On the second day the inspection team comprised of an inspector, an expert by experience and a specialist advisor. An expert by experience is someone who has experience of caring for someone who uses this type of care service. A specialist advisor is a health care professional with qualifications and experience related to the needs of the people the service supports.

We looked at the information we already had about the provider. Providers are required to notify the Care Quality Commission about specific events and incidents that occur including serious injuries to people receiving care. We refer to these as notifications. The provider had completed a Provider Information Return (PIR) and returned this to us within the timescale requested. 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 the information from notifications and the PIR to plan the areas we wanted to focus our inspection on. We contacted the local authority who commission services from the provider for their views of the service.

We spoke with eight people who lived at the home. We met all the other people who lived at the home. Some people living at the home were unable to communicate verbally due to their health conditions. We spent time in communal areas to determine how care was delivered and 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 spoke with the registered manager, and individually with four members of staff. We spoke with five relatives. We looked at records including parts of six care plans and medication administration records. We looked at three staff files including a review of the provider's recruitment process. We sampled records from training plans, incident and accident reports and quality assurance records to see how the provider

monitored the quality of the service.

Requires Improvement

Is the service safe?

Our findings

At our last inspection in April 2015 we identified that there were insufficient staff on duty to meet people's care and support needs. We found the registered provider and registered manager were in breach of Regulation 18 of the Health and Social Care Act 2008. After our inspection we were sent an action plan detailing how the registered provider and registered manager would improve upon this, to ensure the requirements of the law and people's needs would be met. During this inspection we reviewed this situation. We found that some improvements had been made, but the number of staff on duty remained too low to safely meet people's needs in a timely way.

During the inspection there were insufficient staff available to respond to people's requests for support promptly. Relatives that we spoke with told us that there were not enough staff available when they visited the home and comments included, "The staff are all good, but we could do with more. People often have to wait, especially at staff handover." Staff told us that there were not enough staff on shift, although staff did explain how they worked flexibly to cover each other when there was sickness or a request for annual leave by an individual member of staff. The registered manager informed us that they assessed the dependency levels of people regularly using a tool developed by the registered provider. They provided evidence that the number of staff met or exceeded the number as detailed by the staffing assessment. However we saw people having to wait long periods of time for support. Staff were not available to help some people get up out of bed and attend to their personal care until lunch time. People we spoke with confirmed this was usual, and not always people's choice. People were left for long periods of time in their bedroom and in communal areas of the home without staff support or supervision. On two occasions we had to seek staff support on behalf of people that urgently required the assistance of staff. There were no staff in the area and the people had either no means of calling for help or were unable to attract the attention of staff to help them. Failing to have adequate staff to help people meet their health and social care needs is a breach Regulation 18 of the Health and Social Care Act 2008. Regulated Activities 2014.

People told us they felt safe and the comments we received included, "I'm fine here. Thank you," and "Yes, I am safe." One relatives that we spoke with told us, "I like the things they do to keep my wife safe. They tell me about the low bed, crash mat and sensor alarm for example." Another relative told us, "My relative can't tell me how she feels, but usually I see her looking happy and as well as she can be."

The staff we spoke with described the activities they undertook with people each day to ensure they were safe and protected from the risk of harm. Staff described a wide range of environmental checks, as well as care they provided such as turning people to help protect them against sore skin. We found these care actions had been effective, as despite the number of people at high risk of developing sore skin, only one person had sore skin, which was in the process of healing. One member of staff told us, "Yes, people are 100% safe." The staff we met were able to describe the possible signs of abuse and the appropriate action they would take should they have any concerns. Staff told us they had received training in safeguarding to help them understand the procedures to follow and the signs to be aware of. The registered manager was aware of their responsibility to report and respond to any safeguarding concerns that may arise.

Individual risks to people had been identified and some steps had been taken to minimise the risk for the person. In a number of plans that we reviewed the risk assessment tools had been calculated or used incorrectly. This meant the assessment tool had failed to correctly assess the level of risk to the person. This meant there was a risk that people had not been provided with support or equipment that would have been consistent with that risk. The people whose care we looked at in detail, were already at very high risk, and the action taken to protect them was comprehensive, so for these people there had been no negative impact. The risks had been regularly reviewed to ensure that the support given was still appropriate. Where accidents or incidents had happened immediate checks on the persons' well- being were carried out. We saw that accidents were reviewed monthly to see if any preventative measures could be put in place to reduce the chance of reoccurrence. Accident reports were also monitored by the provider to ensure appropriate action had been taken and to share learning across the organisation.

We looked at the staff recruitment practice and found that checks such as a Disclosure and Barring Service Check (DBS) were carried out before staff worked with people. These checks helped to ensure people were supported by suitable staff.

People needed support to receive their medicines. We saw people receiving their medicines in a dignified way and staff offered individual support to help people understand the medicines they were taking. The registered manager had implemented a number of systems to reduce the risk of medicines errors occurring, which included staff wearing tabards informing people they were administering medicine. These ask people not to disturb the staff. They had also provided information sheets for each person detailing allergies and with a photo. We looked in detail at the management of medicines on Ash unit of the home. The audit undertaken by staff and the supplying pharmacy had identified that medicines management was generally good. Our inspection supported this, although we found further work was required to ensure topical medicines such as creams were being used and applied as the doctor had prescribed. People could be confident they would get their medicines correctly.

Requires Improvement

Is the service effective?

Our findings

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 people lack mental capacity to take particular decisions, any decision made on their behalf must be in their best interests and as least restrictive as possible. We checked whether the service was working within the principles of the MCA. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the registered manager had applied for DoLS appropriately and whether any conditions on authorisations to deprive someone of their liberty were being met. The registered manager had made the required applications for DoLS for all people living at the home, some of which had been approved.

Staff we spoke with understood the principles of promoting independence and seeking people's consent but did not know if people residing at Oaklands had been subject to DoLS or if people had mental capacity, and how this impacted on their ability to make choices and decisions. One member of staff told us, "We always ask for consent, explain to people what we plan to do before we deliver any care."

In the care records we looked at we found evidence that showed some people had been subject to a Mental Capacity Assessment and that when necessary this had led to Best Interest meetings being held, and specific plans being developed, for example in the use of covert administration [Hiding medicines in food or drinks] of medicines. We looked in detail at the care of other people and found they had not received these assessments or support, and we could not be confident that people's human and civil rights were consistently being protected.

New staff had completed a period of induction training which included working with a more experienced staff member. One recently recruited staff member that we spoke with told us, "They helped me until I felt confident. That really helped me to learn. I wasn't left alone or rushed." The registered manager understood that when new staff started work they had to complete the Care Certificate. The Care Certificate is a nationally recognised induction course that should be offered to staff to provide them with a general understanding of good care practice. The registered manager had started, but was not fully able to offer new staff this opportunity. Staff had received training in some people's individual needs which had been refreshed at set intervals during the year. While staff told us that they felt they had the skills and experience to meet people's needs the training records showed that some significant work was required to ensure that all the staff had received recent training in the specific needs of people and safe working practices. People were not always supported by staff who had the skills and knowledge to meet their needs.

Some staff told us that they received regular supervisions, other staff told us these were overdue. Supervision meetings provide staff with the opportunity to reflect on practice, raise any concerns and receive support from the management team. Staff reported feeling supported by their colleagues, and the nursing staff as well as the management team.

Some people received the support they required to have their healthcare needs met, and for other people this support required improvement. We saw that most people had care plans which detailed the individual support they required to maintain good health. We saw that healthcare appointments had occurred regularly and specialist advice was sought as and when needed. When we looked in detail at records about people's care we found evidence that staff had identified changes in people's well being, and sought advice from the registered nurse on duty or relevant health care professionals. Advice given had been followed and incorporated into the plan of care. In some cases the change identified by staff was very slight, and this provided positive evidence that staff knew people well, and were observing people closely for signs of change. This ensured these people's health care needs were well met. In some of the plans we reviewed we identified that people had healthcare needs that had not been subject to the same degree of regular monitoring or that a plan of ongoing care was in place. People's needs had been identified at the time of admission, but had not been included in the person's main care plan. Staff we spoke with were not all certain if the person still experienced the health condition they had at admission or if the support they required had changed. This could result in people's needs being unmet, or people receiving inappropriate care.

We observed the meals being served and the support offered to people at meals times over both the days of our inspection. People told us they liked the food, and we observed the food served was hot, varied and smelt and looked nice. Comments from people included, "The food is absolutely Tops" , "The food is good, they serve good portions, sometimes too much" and "The food is okay. They give you two choices." We observed people being given the support they required to eat, and often we heard people chatting and laughing with the staff who were supporting them. Some people had been assessed as being at a high risk of losing weight. We looked in detail at the care and support these people had been given, and found that people had often maintained or gained weight. Staff we spoke with described the enriched food and supplements they offered people to help them gain weight. This showed that people at increased risk of malnutrition and dehydration were being well supported to have their dietary needs met.

While people could be certain their food and hydration needs would be well met, we identified many missed opportunities to make meal times more pleasant and enjoyable for the majority of people. We observed that people were not routinely offered condiments or sauces, people were often brought to the table too far in advance of the meal time starting, and people were not always helped to sit in friendship groups.

Requires Improvement

Is the service caring?

Our findings

People told us they were happy living at Oaklands. Comments from people included, "I've only moved here recently, but they have really helped me to settle," and "All the girls [staff] are lovely. Kind." One person we met had recently experienced a bereavement. They described the support staff had given her, "They have been very supportive it has really helped." We observed and heard staff offering constant reassurance to the person throughout our inspection. Another person we spoke with described the help they needed with personal care. They went on to say, " When they change me they are very gentle." Our observations showed that people appeared comfortable in the presence of staff. We heard staff greeting people with warmth when they approached them, and when they came onto shift.

We saw individual staff treating people with dignity for most of the time. Staff ensured people were taken to a private area when they needed supporting with their personal care needs. We observed staff supporting people to use moving a hoist. Staff took care to cover the person's legs and maintain their dignity. We observed staff knock on people's bedroom doors before entering, and some people had hotel style, "Do not disturb signs" on their bedroom doors when care was being delivered. This all demonstrated a respect of people's privacy. However we also identified occasions when people had not been treated with compassion or had their dignity upheld. One relative we spoke with informed us that their loved one had been confined to bed for a number of years as a moulded chair, suited to their health needs had not been provided. They went on to describe how the person had scratched through mattresses, which in their opinion was a sign of their boredom and frustration. The care records for this person had failed to make clear the plans in place to meet the person's needs or provide them with company and stimulation. Discussion and records showed this person spent long periods of time alone in their room. When another person we spoke with described in detail a competition they had been following on the television. They spoke of how they had been interested in the programme but then expressed frustration that they had been 'sent' to bed, on the night of the final by staff before the programme had finished, and still didn't know who had won.

People were supported by staff who knew them well. The staff team covered vacancies and sickness from within the team which meant people weren't supported by staff they were unfamiliar with. Relatives we spoke with were complimentary about the individual care provided by members of staff. Comments included, "It is smashing here. The staff are great" and, "My relative is always looking clean and fresh."

Many staff had worked at Oaklands for a number of years and had got to know people well. Staff we spoke with described people with enthusiasm and affection as they talked with us. Staff we spoke with told us, "I really enjoy the company of the people I support. I'm especially happy when we find a common interest we can talk about and share," and, "I really enjoy working here and taking care of all these amazing people."

People and where appropriate their relatives were able to contribute to the care plans in order that their view about how they would prefer to be supported was determined. Care plans contained details of how the person liked to be supported and contained important information about the gender of staff people would prefer to them for example. This ensured that people received care how they preferred.

Relatives confirmed that the staff kept them informed of any changes to their loved ones care and condition. One relative told us, "If there are any problems with Mum, they always call quickly."

Requires Improvement

Is the service responsive?

Our findings

At our last inspection complaints and feedback made by people about the service were not being identified, recorded or handled well, and we found this was a breach of regulation 16 of the Health and Social Care Act 2008. Following our inspection the registered manager and registered provider submitted an action plan. This detailed how they would improve in this area. We found that the action plan had been effective, and the handling of complaints was now well managed. The registered provider had provided a computer tablet at the home, that anyone could use to report their concerns. Doing this ensured that senior people within the organisation were made aware of the issue, and communicated with the registered manager about the action they were taking. This had resulted in complaints being recognised and prompt action being undertaken to investigate and resolve the concerns. Relatives we spoke with told us," They have told me I can complain. So far I haven't needed to," and " The manager is usually here in the daytime when I come. She is approachable. I can speak with her about things if I need to."

Access to activities that would provide people with meaningful things to do, and reduce the risk of them becoming socially isolated were very limited. We were informed that there was a separate team of staff who arranged and carried out activities of people's choosing, however this had not been effective. We asked one person who we observed sitting alone for a long period of time if she had anything to do. She replied, "Like what? There is rarely anything to do here." Relatives we spoke with confirmed this and their comments included, "There isn't much for anyone to do. Sometimes I bring cards and play with a few people," and "There was a church service once. She enjoyed that." Some people's assessment prior to admission had included obtaining information about what people had previously liked to do to occupy their time. This information had not been utilised to ensure people had access to activities of interest on a regular basis. Failing to provide people with regular opportunities to meet their social care needs is a breach of Regulation 9 of the Health and Social Care Act 2008. Regulated Activities Regulations 2014.

Records that were available and our discussion with the activities worker identified that isolated, stand alone activities, which included local trips to the shops for a small number of people, and some people being supported to vote in recent local elections had occurred. People we spoke with about these activities had enjoyed them. However on a day to day basis the opportunities provided for the majority of people was poor. People could not be certain they would have interesting things to do, or be protected from the risk of social isolation.

People were supported to maintain relationships that were important to them. People had regular contact with family members. Relatives informed us that they were able to visit whenever they wished and told us they were made to feel welcome when they did so. One relative commented, "They always make me welcome. I am invited to have a meal here, and always offered drinks. There is always a warm welcome."

Care plans had been reviewed regularly by the nurses to ensure the care provided was still meeting people's needs. Relatives we spoke with confirmed they were asked to contribute to the reviews. One relative told us, "They tell me what care she has received, and what she needs. That makes me feel involved. It's important they do that, I have cared for [name of person] myself , and it's hard to let go of it all."

There were systems in place for staff to share important information about the people they were supporting. This included handovers between staff teams that occurred at key points during the day. We observed one staff handover and found it was an effective way of sharing information about people and the support they had received and still required for the day.

Requires Improvement

Is the service well-led?

Our findings

We last inspected Oaklands in April 2015. We found the systems in place to ensure the service would meet the requirements of the Health and Social Care Act 2008 were ineffective. We found the registered provider and registered manager had not met the requirement of Regulation 17 to have an effective system in place to oversee and manage all aspects of the quality of the service provided. The registered provider and registered manager produced an action plan detailing how they would improve this. We looked at the range of audit tools used at the home, and found that the number of these had increased since our last inspection. The registered manager had a range of audits to complete, and the findings of these were shared electronically with the registered provider. The registered manager was then asked to provide feedback to the provider and evidence about the action they had taken to improve or resolve the situation. We found that some progress had been made, but the systems in place were still not effective. Our observation was that the number of audits and checks were overwhelming, and that they did not always ask the right questions to be effective. We tracked the work taken to resolve specific things we observed such as environmental defects. We found these had not been included in the audits completed, and potentially hazardous equipment was left in operation, without a clear plan in place to repair or replace. Similarly we tracked the audits undertaken on care and medicines, and issues we identified during the inspection had not been picked up in the homes own audits.

The premises of Oaklands were in a poor state of decorative repair, and capital investment was required to upgrade some parts of the premises and equipment. We asked the registered manager about the plans and timescale in which this would be achieved. The registered manager informed us there was no development plan, and they were unsure of when or if the work would be undertaken. People could not be certain that they would receive a service that was well governed, and continually developing and improving. This was a breach of Regulation 17 of the Health and Social Care Act 2008. Regulated Activities Regulations 2014.

People and their relatives were happy with the management of the service and one relative commented, "We have two good managers. They are both approachable, participative, hands on and knowledgeable," and another relative told us, "The manager is good. All the nurses are good. I could go to anyone of them, I have confidence in them to run a good home. "

Staff that we spoke with felt supported in their role and were happy with how the home was managed. They told us, "I feel I have enough support," and "Both the manager and the nurses are supportive." The service had a clear leadership structure which staff understood. The registered manager was supported by a deputy manager and a team of registered nurses. Staff informed us that there was always a manager on call that they could contact should they need advice.

In conversation the registered manager demonstrated their knowledge about their responsibility to inform the Commission of specific events that had occurred. They were aware of new regulations and the impact for service delivery. However during our inspection we found that the Statement of Purpose for Oaklands was not entirely consistent with the service we observed being delivered. A large number of people we met were living with dementia or mental ill health, yet the design of the building, care planning and resources to

equip staff to meet such specific needs had not been developed or provided. While this had not had any direct negative impact on people, it did mean that the service was not offering care that was always consistent with current best practice guidance. The provider had not kept the Statement of Purpose under review to ensure it reflected the service being offered. The Commission had not been kept informed of changes to the care provided at the home.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care People had not been provided with regular opportunities to undertake interesting activities that would provide stimulation and reduce the risk of social isolation.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Systems in place to check the quality and safety of the service were not being effective. They had not ensured the service was complying with the regulations or consistently meeting people's needs.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing People were not supported by adequate numbers of staff to ensure their needs could be met in a timely way.