Four Seasons (Evedale) Limited

The Oaks and Little Oaks

Inspection report

172 London Road
New Balderton
Newark
NG24 3BN

Tel: 01636605365
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?	**Inadequate**

Summary of findings

Overall summary

We undertook an inspection of The Oaks and Little Oaks on 2 January 2019. The inspection was unannounced. The Oaks and Little Oaks has been registered since September 2011. The service provides accommodation, personal care and support for up to 73 people in Newark. At the time of our inspection, 46 people were using the service. The service is focused on supporting older people, with a mixture of residential, nursing and respite packages.

People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

At the last inspection, on 27 February 2018, we rated the service as 'Requires Improvement'. During this inspection we again rated the service as 'Requires Improvement'. We found ongoing concerns about the safety of the service, staffing levels and leadership. This included a breach of regulation 9, regulation 17 and regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

There were insufficient staff to meet people's needs. While staff worked hard to meet people's needs, the limited number of staff impacted on the responsiveness of the service. This affected the safety of people living at the service. People's care plans and risk assessments guided staff on how to support people.

We found medicines were managed safely and people received medicines as prescribed. Infection prevention and control procedures were followed. The home was clean. We found that systems and processes were in place to keep people safe from abuse. Lessons were learned when things went wrong.

People were not always supported to have maximum choice and control of their lives. Staff did not support them in the least restrictive way possible; the policies and systems in the service did not support practice. People were not always given adequate support to consume food and fluid. We found relatives sometimes attended to support people when staff were otherwise occupied. This lack of support could put people at risk of malnutrition. The home was not adapted to meet people's needs as there was little navigation guidance for those that were confused. Staff worked effectively with health and social care professionals. We found that staff had received training and had a good knowledge.

Staff worked hard to meet people's needs, however the insufficient amount of staff meant staff had little time to talk to people. Care was instead focused on completing tasks quickly to meet people's needs. Delays in care effected people's dignity. People's privacy was respected and staff requested permission before completing tasks. People needed to be more involved with planning and reviewing their care plans.

People's desired support could not always be responded to due to a lack of staff. There was a lack of

activities to keep people engaged and people told us that they felt under stimulated. Formal complaints had been listened too. Further work was required to engage people who could not engage with a formal complaints process. End of life care was supported in a safe and respectful way.

At the time of our inspection there was a registered manager in place. A registered manager is a person who has been registered with the Care Quality Commission (CQC) to manage the service. Like registered providers they are "registered persons". Registered persons have the legal responsibility for meeting the requirements of the Health and Social Care Act 2008 and associated regulations about how the service is run.

This is our seventh inspection in nearly two years. The provider has failed to sustain improvements at the service. During this time the service has been assessed as either 'requires improvement' or 'inadequate'. We saw that the registered manager had worked hard to improve the service and people spoke positively of her. However, provider level restrictions for staffing levels restricted further improvements at the service. It has therefore remained rated as 'requires improvement'. People were given opportunities to feedback and the service worked effectively with other agencies.

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. There were not enough staff. Systems and processes were in place to keep people safe from abuse. Care plans and risk assessments guided staff on how to support people. Medicines were managed safely. The home was clean. Lessons were learned when things went wrong

Is the service effective?

Requires Improvement

The service was not always effective. Mental capacity assessments required improvement. People who required additional support to eat did not receive this. Staff had received training and worked effectively with health and social care professionals.
The home was not adapted to meet people's needs

Is the service caring?

Requires Improvement

The service was not always caring. Staff were well meaning, but a lack of staff meant limited time to spend talking to people. Delays In care effected people's dignity. People were not always actively involved with making decisions about their care. People's privacy was respected

Is the service responsive?

Requires Improvement

The service was not always responsive. People were unable to maintain their desired routines due to a lack of staff. People's anxiety and confusion was not always recognised and responded to by staff. There was a lack of activities to keep people engaged. Formal complaints had been listened too. Further work was required to engage people who could not engage with a formal complaints process. End of life care was supported in a safe and respectful way

Is the service well-led?

Inadequate

The service was not well led. The provider has failed to sustain improvements at the service. People were given opportunities to feedback. The service worked effectively with other agencies.

The Oaks and Little Oaks

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 comprehensive inspection took place on 2 January 2019 and was unannounced. The inspection team consisted of two inspectors, an expert by experience and Specialist Advisor. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service. A Specialist Advisor is a health and social care professional who can provide expert advice on the service. The specialist advisor for this inspection was a registered nurse.

Before the inspection took place, we gathered information known about the service. We considered notifications the provider had sent to us. A notification is information about important events which the provider is required to send us by law. We also considered any information received from the public and professionals. We used this information to plan our inspection.

Before the inspection we requested the provider submitted a Provider Information Return (PIR). We used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make

During our inspection, we carried out general observations of care and support and looked at the interactions between staff and people who used the service. We spoke with seventeen people who used the service and ten relatives or visitors. We spoke with four care staff, two nurses, three domestic staff and the registered manager. We looked at the relevant parts of the care records of eight people who used the service. We also looked at three staff recruitment files and other records relating to the management of the home. This included audits, policies and incident records.

Requires Improvement

Is the service safe?

Our findings

There were not enough staff to meet people's needs. While care plans and risk assessments guided safe care, there were insufficient staff to ensure people's needs were met promptly according to the care plans. People living at the service often required staff to support them to use the toilet. We saw this support was delayed. One person asked to go to the toilet and waited 15 minutes until staff supported them, they explained to staff that they were uncomfortable but staff were busy supporting other people. A relative told us, "Sometimes [person's] said they ask (to be taken to toilet) and they can't get to [person] in time and [person's] done it". This placed people at risk of discomfort and distress.

People's call bells were not responded to quickly, this affected people's safety as their needs were not met promptly. Call bells were important as some people remained in their room and could not easily call for staff support. Others had call bells linked to automatic sensors for immediate assistance as they were unable to call for support. Throughout the inspection visit, the call bell system was sounding and there was a delay in staff response. For example, we saw three bells took 20 minutes to be responded to. Staff told us they were too busy supporting people to respond to call bells quickly. A person told us "The call bells go all day and night. It keeps me up at night. You hear people shouting after a while and staff going to help. There's not enough staff to be quick to respond."

There were not enough staff according to the managers dependency tool. This dependency tool identified that 10 staff were needed to meet people's needs. However, only 8 staff were provided. We saw the reduction of two staff had a negative impact on people throughout the day. People were not responded to quickly and this put their safety at risk.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes were in place to keep people safe from abuse. People told us they felt safe living at the service. Records showed that any concerns about abuse were recognised and reported to the relevant Local Authority to investigate. Staff had a good knowledge about when to report a safeguarding concern, and had confidence that concerns would be acted on appropriately. One staff member said "In our training they teach us about what abuse is and what to do. If I wasn't happy that the manager had dealt with it I would go higher to senior people." Records showed us that if incidents had occurred then an 'incident report' was completed. This identified areas of learning and changes were made to keep people safe.

Records showed us that people's physical and mental health conditions were risk assessed. Clear care plans guided staff to care for people safely, records showed us that the care plans were correctly followed. For example, people who were at risk of skin breakdown from pressure damage had a clear care plan in place to guide staff on how to support them. Records showed us, and people told us that regular repositioning occurred. Staff were able to explain what skin changes would cause concern and how they would respond by making referrals to health care professionals.

The necessary steps had been taken to ensure people were protected from staff that may not be fit and safe to support them. For example, before staff were employed, criminal records checks were undertaken through the Disclosure and Barring Service. These checks are used to assist employers to make safer recruitment decisions. Nurses were employed at the service. We saw that the provider had good oversight of their qualifications and nursing registration.

Medicines were managed safely. A person told us "(Staff) deal with my medication fine. They always bring me my pills wherever I am and tell me it's time for them. I have no worries." There was a sufficient stock of medicines to meet people's needs. We saw that medicines were stored at the correct temperature and safely locked away. Medicine administration records were completed accurately to show that people were receiving medicines as prescribed.

Infection prevention and control procedures were followed to ensure people remained safe from potentially transferable illness. The home was clean and we observed staff using personal protective equipment and appropriate cleaning routines. Since our last inspection, there had been an outbreak of flu at the home. Records showed us that this had been responded to appropriately, by informing public health and restricting visitors to the home.

Incidents were responded to appropriately and lessons were learned when things went wrong. There was a clear process for staff to complete 'incident forms' when an incident had occurred. For example, a staff member had made a mistake with incorrect medicine dosage. Medical advice was sought and the person received their remaining medicine dose soon after. The staff received refresher medicine training and competency assessment to ensure the same mistake would not be repeated.

Requires Improvement

Is the service effective?

Our findings

The Mental Capacity Act (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. We checked whether the service was working within the principles of the MCA.

We found that mental capacity assessments and best interest decisions had been documented. However, the quality of these were variable. Some assessments were unclear and did not document clearly how the person's decision making had been assessed. Others were of a very good quality and showed that attempts had been made to support decisions in line with guidance. We recommended that the provider ensures mental capacity assessments were of a consistent good quality across the service.

People can only be deprived of their liberty to receive treatment and care when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). The registered manager had a clear record of who was subject to a DoLs. We viewed these files and saw that these DoLs were managed appropriately and clearly documented in care files.

There was a risk people may not have enough to eat. People who required additional support to eat did not receive this. Staff were otherwise occupied and did not always notice when additional support was required. For example, one person stated that their glass was too full to lift. Staff were busy, so a visitor took time to support the person to drink. A visiting relative told us "I have to come in and help (person) with their meals, they need encouragement. Staff haven't got the time." One person's care plan stated that they required encouragement and supervision to eat. We saw that staff were busy and this person spent twenty minutes eating their meal with their hands. Staff support was only offered once we alerted the registered manager to this person's difficulty. People spoke positively about the quality of the food.

Care plans were based on evidence based guidance. This meant staff were guided to support people in an effective way. For example, people who were at risk of skin breakdown had their skin integrity assessed using a nationally recognised tool. This calculated a level of risk and guided staff on appropriate care. We saw that if people's needs changed, this tool was re-used to calculate if changes in care were required.

Staff worked effectively with health and social care professionals. A person told us, "If you ever say you don't feel right or something, they check you straight away. They'll always get a doctor if you need it, or they feel you need it." Records supported this, with people's health concerns being referred to the correct professional and follow up checks being completed. The service employed trained nurses to meet people's nursing needs, these nurses worked effectively with the staff team and recognised when additional medical advice was needed. One person had arrived with a complex and serious pressure injury. The nursing team had contacted external specialist Tissue Viability Nurses. Their specialist advice had been clearly

documented and followed.

Staff told us that training was effective and gave them enough information to carry out their duties safely. One said, "There is lots of training here, it's good." We looked at the training data and saw that staff training was up to date and covered areas essential to the role. For example, all staff had completed safeguarding training. Staff knowledge throughout the inspection was very good, and demonstrated that the training had been effective. Records showed us that staff were provided with regular supervision with the registered manager.

Requires Improvement

Is the service caring?

Our findings

Due to insufficient staff, we saw that staff rushed around and interactions were task focused to meet people's immediate needs. We did not see staff taking much time to talk to people, or interact with them on an individual level. One person was still in bed at 12:00pm. They said they were not interested in moving to a communal area because no-one would have time to talk to them. Those people who were in the communal area were only spoken to if they made repeated efforts to get staff attention. A visitor told us, "Staff have a lot to contend with, they always appear to be under pressure but they still treat people with respect and have a sense of humour". Another visitor said, "I think they [staff] feel awful making people wait, they really do try." We found that while staff were well meaning and working hard to meet people's needs, the insufficient amount of staff meant caring interactions were not promoted. This did not meet people's needs or promote their dignity.

Staff did not always respond to people's distress and discomfort. Because staff were busy, they did not always notice if people became confused or upset. We saw people walking in corridors without purpose, and staff did not recognise this and guide them to a comfortable place. This left people confused and without support. When staff did recognise a need, the interaction was positive and caring. We saw a staff member crouch down to eye level with a person that was upset. They held the person's hand and stroked their arm whilst offering reassurance. We saw that the person did appear to relax and said to the staff member, "You do look after me don't you."

People were not always actively involved with making decisions about their care. Care plans showed us that some choices had been recognised and promoted. For example, people's favourite meals. However, further choice needed to be encouraged. For example, further work was required to identify which gender carer people would prefer. We asked one person if they had a choice over the gender of their carer. They responded, "They never asked me but if the ladies are busy (male carer) does it (personal care task). He's funny but treats me right, with respect." As people's preferences were not recognised, there was a risk that preferred routines would not be followed.

People's privacy was respected by staff at the service. A visiting relative said "I've not seen anything untoward. I think staff respect people, there's a lot of laughing and joking but it is respectful. They (staff) are discreet, private, they close doors and curtains when they are helping [family member]". Throughout the inspection, we saw that staff asked permission to enter people's bedrooms and complete care tasks.

Requires Improvement

Is the service responsive?

Our findings

People did not always receive personalised support that met their needs. People did not complete routines as they would like. A person told us that that they and three others had remained in the communal lounge until midnight. One person had woken at 8:30am, and remained in bed until 11:45am despite wanting to get out of bed. They added "They will help me now because it's dinner time and I'll go downstairs."

Care was not always responsive to people's needs. Care plans required some people to be checked on hourly. Records showed that some people waited longer than an hour. We were also concerned that records were not filled in accurately. For example, we saw one person's check was completed 36 minutes late. However, records completed by staff suggested it was only 20 minutes late. This late support did not meet the person's needs and the inaccurate recording did not give an accurate picture of this support delay.

We saw staff did not always notice people who required support for their anxiety. Once they did respond to people, their support was effective. One person became upset as they believed that their tablets had been forgotten. They remained upset for thirty minutes and had phoned their family for emotional support, before staff attended and provided reassurance. When staff did attend to people, we saw that staff responded effectively to this anxiety to give people reassurance. When asked about behaviour that challenges staff, one visitor said, "That happens on the odd occasion but they (staff) soon deal with it, they are very firm but not heavy handed, they are gentle, they lead them away and give them something else to do."

People appeared unstimulated, there was minimal staff interaction and on the day of the inspection no formal activities occurred for people. A relative said, "Maybe they do activities, but every time we come they seem to be sat. [Person] gets bored". Two relatives told us that they were concerned about the lack of activities, so now volunteer to help. People spoke positively about this voluntary help. Another relative told us that they had complained about the lack of activities but there was no change. The registered manager told us they had a dedicated activities co-ordinator for 30 hours a week. However, the scope of their role also included aspects of care planning. We were concerned that this limited the amount of time they could commit to people's activities. Further work was required to ensure that activities were effectively co-ordinated in the home.

The home was not adapted to meet people's needs. There were minimal adaptations to assist those who were confused with orientation about the homes. Signs around the home were at an inappropriate height for people to read. People's individual room doors were numbered. However, there was no obvious markers to assist people to find their room if they were disorientated. Documentation around the home was not in plain and accessible formats. We expressed concern that the home was not fully adapted to meet people's needs. The registered manager assured us that she would work to improve this.

There was a risk people's concerns and complaints may not be treated with equality. Formal complaints had been listened to and responded to effectively in line with company policy. People had been approached to check they were happy with the outcome and for the complaint to be closed. Further work was required

to ensure non-formal complaints were also respected and responded to. For example, if people voiced negative opinions in a meeting; these were not treated with the same quality of response as a formal complaint to a staff member.

Communication through meetings and complaints procedures were limited to those people who could easily communicate. There was no process in place to engage people with communication difficulties in the resident's meeting (for example picture cards). The complaints policy did not come in an easy read format for those requiring support. During the inspection, one person wished to raise a formal complaint however told us that they were unsure how. We asked the registered manager to speak to them. We are concerned that there were no processes in place to ensure those less able to communicate had their opinions heard.

This lack of person centred support was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Care plan's did reflect people's diverse needs. Records documented people's religious needs and how the person would like these needs catered too. We saw there were posters around the home advising people when religious visitors were coming to visit. We saw people's privacy was also respected with this, and where people declined to disclose their personal beliefs this had been respected. The recording of people's diverse needs, meant that their individuality could be responded to effectively.

End of life care was supported in a safe and respectful way. We saw that people's end of life wishes had been explored and met where ever possible. Where people had arrived at the service with a 'Do not Resuscitate' document, care was taken to explore the suitability of this and approach medical advice if the person later changed their mind. We saw that careful and respectful arrangements were in place for people who had passed away at the service. This meant people's death would be treated with respect and care

Inadequate

Is the service well-led?

Our findings

The provider had failed to sustain improvements. The Care Quality Commission have previously highlighted insufficient staffing in March 2016 and June 2017. Despite our concerns, low staffing levels have not been consistently maintained at a safe level and concerns remained at this inspection. These concerns about insufficient staff had been highlighted to the provider by the registered manager, staff and people using the service. However, concerns had not resulted in change. Despite the low staffing levels, we saw staff work hard to meet people's needs. However, without staffing increase, poor quality care inevitably continued to occur.

Since January 2016, we have visited this service 7 times. Throughout all inspections this care home has remained rated overall as "requires improvement" or "inadequate". We expect all services to reach an overall rating of 'Good', so are concerned about the failure of the provider to improve this service. The registered manager and staff worked hard to create a positive environment for people at the service, staffing restrictions affected the impact of this during this inspection.

Audits to assess the suitability of staffing levels were ineffective. The registered manager advised that they completed spot checks, to see how long call bells take to be responded to. Their records showed they had only done this 5 times in 2018, all of which were in September. Verbal feedback from staff, residents and relatives had been ineffective. The lack of oversight of low staffing levels, has resulted in continued unsafe staffing levels.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People and their relatives were consulted in the running of the service. Residents and relative's meetings were provided, so people using the service could be engaged with. A relative told us "They have meetings. I'm always bringing up that they need more staff. They are worthwhile, I do feel they listen." We read minutes from these meetings and found that where the manager was able to make a change, then improvements were made. However, if changes were reliant on significant budget authorisations, then change had not occurred quickly. For example, people had fed back about low staffing levels repeatedly and while this had been reported by the registered manager to the provider, change had not occurred.

7 People and staff fed-back positively about the registered manager. They explained that the registered manager was supportive, approachable and fair. We saw they had approached challenges in the home positively, and any investigations had been fair and well evidenced. It was clear the registered manager was striving for improvement. It was clear from records that they were open to feedback in order to improve the service.

The service worked positively with visiting professionals. Records told us that professional advice had been sought and followed. The registered manager described how she attended meetings with the Clinical Commissioning Group and palliative care team, to ensure they were following best practice.

The provider has a legal duty to display the CQC inspection rating in the home. We saw this was displayed from the last inspection. The provider also has a legal duty to notify CQC of events that occur in the home. This allows us to monitor the risks of the service. The provider has provided timely notifications since the last inspection. The provider is therefore complaint with our legal requirements in these areas

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care People did not have personalised care according to their needs and wishes. People did not always complete routines as they would like

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to sustain improvements. They had failed to adequately respond to concerns raised.

The enforcement action we took:

Notice of proposal - conditions

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing There were insufficient staff to respond to people's needs effectively and promptly.

The enforcement action we took:

Notice of Proposal - conditions