HC-One Limited

Oakland (Rochdale)

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service effective?	**Good**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

Oakland is located in Rochdale. The service provides accommodation and care for up to 40 older people, some of whom are living with dementia. On the day of our inspection, there were 38 people living at the home. The home is on two floors, with capacity for 18 people on the dementia unit on the ground floor, and 22 people on the residential unit on the first floor.

The inspection took place on 2 August 2017 and was unannounced.

There had not been a registered manager at this service for a period of three months. However, a new manager had been appointed and had started the registration process. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered providers and registered managers 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.

At this inspection, we identified breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These were in relation to person-centred care; dignity and respect and staffing. You can see what action we asked the provider to take at the end of this report.

Staffing levels were not sufficient to meet the needs of people. People had to wait for assistance with their personal care and continence needs, and were reluctant to ask for help because of this.

Staff were under pressure in their roles, which meant some interactions with people were abrupt.

People were sometimes placed in undignified situations and were not always treated with respect. People and relatives had voiced dissatisfaction about the lack of dignity afforded to people.

People could not enjoy their individual hobbies and interests, which led to feelings of boredom. Although people had life history care plans in place regarding their interests, not all had been completed.

Although there was a system for responding to complaints, not all complaints had been investigated fully.

The home had been through a period of managerial instability, which meant not all the issues identified at this inspection had been acted on. Staff morale had been low, and staff absence high.

People were supported to maintain their health. People's individual dietary needs were catered for , and people received assistance with their eating and drinking needs. People enjoyed choice and variety of meals and drinks.

The new manager had identified areas of improvement for the home and had started to instigate positive

changes.

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 is not always safe.

Staffing levels were not sufficient to meet people's needs. Staff were under pressure in their roles, which affected the care people received.

People received their medicines safely and as prescribed. Risks associated with people's individual care and support needs were known by staff.

Is the service effective?

Good

The service is effective.

People enjoyed choice and variety in the food and drinks provided. People were supported to maintain their health, with referrals made to a range of health professionals, as required.

Is the service caring?

Requires Improvement

The service is not always caring.

People's dignity was not always maintained. People were not always treated with respect.

People's friends and relatives could visit freely. People's individual communication styles were known by staff.

Is the service responsive?

Requires Improvement

The service is not always responsive.

People could not enjoy their individual hobbies and interests, which resulted in them feeling bored. Although there was a system for capturing and responding to complaints, not all complaints had been fully investigated.

People's changing health and wellbeing needs were responded to.

Is the service well-led?

Requires Improvement

The service is not always well-led.

There had been a period of managerial instability at the home, which had affected the care people received. The provider had not identified all of the issues we identified during the course of our inspection, or taken steps to resolve these.

The new manager had improvement plans in place and had the support of the provider. People and relatives were positive about changes which had already been made.

Oakland (Rochdale)

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 was a comprehensive inspection, which took place on 2 August 2017 and was unannounced.

The inspection team consisted of one Inspector and one Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service. They had knowledge and experience of care for older people.

Before our inspection, we reviewed information held about the service. We looked at our own system to see if we had received any concerns or compliments about the home. We analysed information on any statutory notifications we had received from the provider. A statutory notification is information about important events which the provider is required to send us by law. We contacted representatives from the local authority and Healthwatch for their views about the home. We used this information to help us plan our inspection of the home.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. This information helped us to focus our inspection.

We observed how staff supported people throughout the day. As part of our observations, 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 10 people who lived at the home and three relatives. We spoke with the manager, the area director, and five members of staff. We looked at two care records, which included risk assessments, capacity assessments, healthcare information and life histories . We also looked at 10 medication administration records; comments and feedback received, including complaints; and a sample of the

provider's audits, including falls audits and analysis.

Requires Improvement

Is the service safe?

Our findings

We asked people, their relatives and staff whether they thought there were enough staff to safely meet people's needs. People, relatives and staff consistently told us the staffing levels were not enough in relation to meeting the needs of the people living at Oakland. This was particularly in relation to the residential floor. For example, one person we spoke with told us, "They're really short-staffed here and I need two people to take me to the bathroom. One morning, I asked to go to the toilet and I was told I had to wait until everyone was up and dressed. I always have to wait and that is why I don't like it here; there are too many time-restrictions." Another person we spoke with told us, "The worst thing is when you want to go to the toilet. I sometimes have to wait half an hour. I absolutely dread wanting to go; I have had to learn how to control it." A relative we spoke with told us staff were, "grossly overworked."

Staff told us, and we saw in care records, there were eight people living on the residential floor who required two members of staff to assist them with needs. This included personal care, mobilising and eating and drinking. The staff ratio was two staff members and one senior to 22 people. The senior member of care staff had additional responsibilities, such as medication, which meant most of the daily care tasks were carried out by two carers. Staff told us this ratio was not sufficient to meet people's needs, and people's care was suffering as a result, particularly in relation to personal care needs and staff response times. We saw recent complaints from relatives about staff response times and the length of time people had to wait for staff assistance. One person told us in a five week period, they had only had one bath and one shower. We spoke with staff, who confirmed the person had only been bathed twice. One member of staff told us, "We're getting behind on personal care, people are missing out." Another member of staff told us, [person's name] gets upset because we can't respond to their buzzer as quickly as we would like. During a twelve hour shift, [person's name] presses the buzzer for staff help at least 10 times and we can't just drop everything and get to them quickly." We discussed these concerns with the manager and the area director, who showed us they had started an exercise to review people's dependency needs and staffing levels. However, no immediate action had been taken, such as arranging for additional staff cover whilst the staffing levels were reviewed.

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

We looked at whether people were protected from harm and abuse, including bullying and harassment. We observed that some staff interactions with people were abrupt. We raised this with a member of staff, who told us, "When we are stressed, they are stressed." A person we spoke with told us, "The day staff are lovely, but I don't look forward to the night staff coming on duty. Some of them can be really quite off with us." We discussed our concerns with the manager and the area director. The manager told us that since starting their role two weeks' ago, they had identified a couple of members of staff who did not demonstrate the right attributes for the role and that this would be addressed through disciplinary action, if necessary. The area director told us that staff's behaviours were constantly reviewed, and staff were made clear as to what was acceptable and unacceptable behaviour. Following our feedback, the area director told us staff behaviours would be re-visited.

The risks associated with people's individual care and support needs had been assessed, and risk assessments were in place for areas such as pressure care; choking; and oral health. Staff we spoke with were aware of people's individual risk assessments and how to keep them safe. For example, staff knew which people needed the assistance of two carers to assist them with their mobility needs. Staff understood how to recognise signs of abuse or harm. One carer we spoke with told us possible signs of abuse or harm were unexplained bruising and injury, as well as changes in mood and behaviour. Staff told us they would alert senior carers or management to any concerns, and they were confident that action would be taken to keep people safe. Before staff members were allowed to start work, checks were completed to ensure they were safe to work with people. We saw that references and checks with the Disclosure and Barring Service (DBS) were completed and once the provider was satisfied with the responses, they could start work. The DBS helps employers make safer recruitment decisions and prevent unsuitable people from working in care.

We looked at whether people received their medicines safely. People told us they received their medicines when they should, including any 'as required' medicine. Medicines were administered by senior carers only, and their on-going competency in the role was routinely assessed by management. The senior on duty we spoke with was knowledgeable about people's individual prescriptions and how these were to be administered and stored. We looked at a sample of medication administration records, which did not contain any unexplained gaps. The manager had arranged for a GP to review the home's 'as required' medication protocol, particular in relation to the use of anti-psychotic medicines. This was to ensure people received these medicines safely and not in excess.

Good

Is the service effective?

Our findings

People and relatives told us they generally felt that staff had the necessary skills and knowledge to do their roles. However, relatives and staff told us they though further training and guidance was required for staff in relation to dementia-specific training, particularly around behaviours which challenge. The area director told us that all staff undertook the provider's five stage "Hearts and Minds" programme, part of which included face-to-face dementia-specific training. Staff were at different stages of this training programme. Our observations throughout the course of the inspection were that staff demonstrated a good understanding of dementia. For example, staff told us about the benefits of reminiscence work with people. We saw this work carried out in the afternoon, with one member of staff telling us, " They (people) are so much more alert afterwards." This was reflected in our observations after the activity had taken place.

People told us they enjoyed the meals at Oakland and that they had choice and variety. One person we spoke with told us, " The food's not bad at all. If anything, they give you too much, which isn't a bad thing. They bring me down for breakfast about 10am, which is my choice." Before lunch, people were shown the options so they had a visual aid to help them to decide. We looked at how people were supported with their eating and drinking needs. Where people needed 1:1 assistance with eating and drinking, this was provided. Staff encouraged people to eat and drink, whilst going at people's own pace. A choice of drinks and snacks were provided to people throughout the course of our inspection, and people told us they were normally offered these.

People were supported to maintain their health. People's care plans had communication records detailing conversations with health professionals, including GPs, district nurses and urologists. People's weights were routinely taken and monitored, with a weight loss of 2kg or more triggering a review. We saw examples of where referrals had been made to GPs, dieticians and the Speech and Language Therapy team over concerns about people's weight loss, loss of appetite or difficulties in eating and drinking. Care plans had been updated following guidance received from these health professionals, and this was known and followed by staff.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

Where people lacked capacity to make specific decisions, meetings were held with the person, as well as relatives and health professionals where applicable, to ensure staff acted in that person's best interests. For example, two people received their medicines covertly, and the best interest decision-making process had been followed when making this decision. Staff we spoke with demonstrated recognition that people could have capacity to make decisions in some areas, but not others. There was also a recognition that people's capacity could fluctuate. One member of staff told us, [Person's name] capacity changes daily. Sometimes, they do have capacity to retain what you tell them and give their consent, but the next day might be totally

different."

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 and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

At the time of our inspection, people living at Oakland had been assessed in respect of their individual care and support needs, and the provider had ensured DoLS applications had been submitted accordingly. Staff we spoke with had an awareness of how many people had a DoLS in place, and what these restrictions meant for people. Where conditions were in place in regard to the individual authorisations, these were adhered to.

Requires Improvement

Is the service caring?

Our findings

We considered whether people were treated with dignity and respect. Although we saw some positive interactions between staff and people living at Oakland, people were not consistently treated with dignity and respect. For example, a person's skirt was wet from urine. The person was wringing their skirt out and was visibly uncomfortable. Although there were two staff present in the communal lounge where the person was, neither of them attended to this person. We brought this to the attention of a carer, whose response was. "Are you sure [person's name] hasn't just spilt a drink down them?" Regardless of how the skirt was wet, it was not dignified for them to be in wet clothes.

When the carer did attend to the person, the person said they did not want to go to the bathroom to get changed, and asked for the carer to bring a clean skirt down for them to change into. The carer told the person they had to go into the bathroom as they couldn't get changed in the lounge. This upset the person and they refused to go to the bathroom. We asked the carer if there was a dignity screen which could be used so the person could change in the lounge, as they wished. We were told, "What is one of those? We've never done it that way before; we take people to the bathroom." We discussed this with the manager and the area director, who told us they had identified the need for a dignity screen and had ordered one.

One person we spoke with told us they were sometimes placed in undignified situations. They had a medical condition which meant they frequently needed the toilet, and their care plan reflected this. The care plan also stated the person, "does not like to wait too long to be taken to the toilet." The person needed two carers to assist them with their toileting needs. They told us that some staff members became frustrated by the amount of time they needed to go to the bathroom. They told us, "[One carer] said to me, 'You can't possibly need the toilet again? You've only just been!" The person told us this had made them feel embarrassed. We saw this person's relative had made a written complaint about the lack of dignity in this regard. We raised this with the manager and the area director, who told us this was unacceptable and they would investigate the matter. The area director told us refresher training would be arranged for staff in dignity and respect, as well as discussing it with staff in their 1:1 meetings.

This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We asked people and relatives if they felt staff demonstrated a caring approach to people. One person we spoke with told us, "Staff go out of their way to do what they can for people." A relative we spoke with told us, "They do the best they can in challenging circumstances. They are all so busy." We saw examples of where staff were busy with their tasks and did not have time to interact with people. However, we also saw instances where staff demonstrated a caring approach. For example, one person had fallen asleep in an awkward position in a chair. A member of staff saw this, and gently placed a cushion behind the person's head to make them more comfortable. Two carers had recently been awarded the provider's "Kindness in Care" award.

People and their relatives told us there were no fixed visiting times and that friends and relatives were

always welcome. One relative we spoke with told us, "You can come and visit whenever you like, and you can stay as long as you want. We're sometimes given meals together as a couple, which is lovely."

People had individual communication care plans, which set out their personal communication needs, styles and preferences. Staff we spoke with told us the importance of tailoring their communication style to suit the individual they were speaking with.

Requires Improvement

Is the service responsive?

Our findings

At the time of our inspection, there had not been an activities coordinator in place for a period of four months. The manager and area director told us that they accepted this had affected people's levels of stimulation within the home, and that people had not been able to go out to places they wanted to. One person we spoke with told us, "I wish they'd do more. The only time I get to go out is when I see the chiropodist." This person's care plan recorded the person enjoyed going to the pub, watching snooker and football and playing a particular sport. However, the person told us they did not get opportunity to enjoy any of these hobbies and interests. Another person we spoke with told us, "I am so bored; I would like to go out. There's nothing for me to do." This person's relative told us, "They (people at the home) don't even get an hour's fresh air." Another relative we spoke with told us, "There is a dart board in the lounge, but am not sure why as no one uses it."

A relative we spoke with told us, "I think it gets very boring for people, there's not much to do. They sometimes get an entertainer in, which breaks up the monotony a bit." They told us their relative had always enjoyed playing bowls. We asked whether there was an indoor bowls kit for the person, and other people, to use, but there was not. We looked in this person's care plan regarding their hobbies, interests and life history. Although there was a section in the plan called an 'activity and social care and support plan', it was blank. This meant that new and agency staff would not have any information to read about this person's interests and preferences. We brought this to the attention of the manager, who told us this person's needs would be reviewed and recorded in this regard.

The area director told us an activities coordinator had recently been appointed and would start work shortly, which would mean people could take part in more group-based and 1:1 activities. The manager told us some of the plans in place were creating an in-house pub for people to enjoy. During the afternoon of our inspection, a member of staff initiated a reminiscence session for people. This involved looking at items such as ration books, which we saw then generated discussions between people and they enjoyed sharing their memories. Staff told us they rarely had time to carry out such sessions with people.

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

We looked at whether there was a system for capturing and responding to complaints, as well as feedback and concerns. Whilst we saw there was a system in place and people and relatives knew how to complain, we found that not all complaints had been investigated fully. For example, one person told us they had complained about being put to bed by a carer in just an incontinence pad. This complaint had been considered, but not resolved due to the fact the person said it was a male carer, and no male carers were employed at the home. However, male agency carers worked at the home, and this had not been taken into account. We raised this with the manager, who told us the complaint would be re-visited.

We looked at whether people's changing health and wellbeing needs were responded to. We saw that people's care was regularly reviewed in conjunction with relatives and health professionals to make sure any

changes were picked up on and responded to. One review had been held regarding a person's disturbed sleep. The person's relative mentioned the person had always preferred heavy quilts and extra pillows, which were subsequently arranged for the person and their sleep improved. These were subsequently provided to the person and their sleep improved. We saw relevant health professionals were sought where there were concerns about people's health. On the day of our inspection, a GP visited the home in response to concerns raised by staff about a person's wellbeing.

Requires Improvement

Is the service well-led?

Our findings

At the time of our inspection, there had been no registered manager in post for three months. The previous registered manager had only worked at the home for 10 months, which meant there had been a period of managerial instability and disruption. However, a new manager had been appointed two weeks' prior to our inspection, and had started the process of registering with the Care Quality Commission. During the three month period without a registered manager, the home had been managed by the deputy manager and a relief manager, with the area director overseeing the home. Although interim measures had been put in place to provide management cover, we found these managerial changes had affected the care people received. For example, although staffing levels had been reviewed by the provider during this time and an extra carer put in place for the morning shift, this had not fully addressed the issues regarding response times and people's personal care needs Additionally, staff told us morale had been low during this period, with uncertainty about their roles and how these were to be carried out. We saw that staff absence levels were currently high, which the manager and provider were aware of and investigating.

We spoke with the manager about what they saw as being the priorities for the home. They told us, "Refinement and fine-tuning of some of our practice." They told us they did regular 'walk-arounds' on the floor, and used this as an opportunity to address any poor practice, such as in relation to dignity and respect. However, at the time of our inspection we were not satisfied these walk-arounds were effective, as issues regarding dignity and respected were identified during our inspection, which the manager was unaware of until we brought to their attention. The manager told us, " Staff need to know what good practice looks like, they won't know unless they are shown."

The manager had already identified the concerns we brought to their attention, and showed us documentation regarding action they had already taken, and action they planned to take. For example, one of the priorities was re-assessing people's current dependency levels and looking at whether more staff were needed. The manager told us they felt supported by the provider in their role, and also in effecting positive change at the home. The area director confirmed with us they would be supportive of any improvements the manager identified as needing to be made. However, whilst the manager had identified that staffing levels was an area of concern during their two weeks of working at the home, the provider had not previously identified this themselves, Furthermore, the complaints the service had received showed a theme in relation to staffing levels and the effect in relation to people's care, yet no immediate action had been taken by the provider to address this. For example, staffing levels had not been increased as an interim measure whilst people's dependency needs were reviewed.

When asked what the priorities for the home were, the area director told us the décor of the home, and that a refurbishment plan was in place. This response did not assure us that the issues regarding staffing levels, dignity and respect and the lack of stimulation for people had been previously identified by the provider through their quality assurance measures,

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

People and relatives we spoke with told us that although the manager was new in post, they felt encouraged by their approach. One relative we spoke with told us, " Since the new manager has arrived, things have perked up a bit. We had a relatives' meeting last week and they have improvement plans in place." One relative we spoke with told us, "[Manager] held a relatives' meeting when they started. I liked what they had to say." We saw one of the concerns raised in this meeting by relatives was people's laundry and how this continually went missing. The manager had looked into possible solutions for this, and was trialling a new system. The manager told us, "It's about saying to people look, I can't promise it won't happen again. But that I will do my best to look at ways of fixing the problem, and any other issues raised."

The manager told us they were looking at ways in which to involve people and relatives in the running of the home. One measure they intended to introduce was relatives carrying out lunchtime audits and then reporting on any concerns they had, or any good practice they had witnessed. They also wanted to have regular residents' and relatives' meetings to encourage open communication and to look at any concerns or suggestions people had.

The provider and manager routinely monitored the quality of care provided to people. Audits were in place for areas such as medication; pressure care and falls. The provider showed us their falls analysis audit, which identified where falls were happening for individuals, and any patterns in time-frames during which individuals had fallen. This information had been used to look at risk factors and triggers for falls for people and to put preventative measures in place, which had resulted in a reduction of falls.

The provider had, when appropriate, submitted notifications to the CQC. The provider is legally obliged to send the CQC notifications of incidents, events or changes that happen to the service within a required timescale. Statutory notifications ensure that the CQC is aware of important events and play a key role in our ongoing monitoring of services.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care People were not able to pursue their individual hobbies and interests, which resulted in feelings of boredom and dissatisfaction.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People were placed in undignified situations. People's personal care needs were not always attended to.

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	Regulation 17 HSCA RA Regulations 2014 Good governance Themes raised in complaints about the service had not all been addressed. Where quality assurance measures were in place, these had not been effective in making improvements to the service.

The enforcement action we took:

Warning notice.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staffing levels were not determined by people's needs. There were not enough staff to meet people's needs safely in relation to mobilising, eating and drinking, and personal care.

The enforcement action we took:

Warning notice.