Care Quality Commission

Oaklands Care Home Limited

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Inspection report

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Date of inspection visit: 19 October 2015
Date of publication: 01/12/2015

Ratings

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

Overall summary

The inspection took place on the 19 October 2015 and was unannounced.

The service provides accommodation for up to fourteen older people. There were thirteen older people using the service at the time of our inspection. There was a registered manager in post.

A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

During our inspection we observed kind, considerate care by staff who were experienced and knowledgeable about the people they were supporting. People told us they were satisfied with the service and we saw there was a quality assurance process in place to assess the effectiveness of the service. This took into account people's views so the service could be provided around people's needs. This was strengthened by having care plans which told staff about people's wishes and choices to help staff provide person centred care. However some care plans viewed were contradictory.

There were enough staff to meet people's needs but the redeployment of staff at lunch time and to help assist with more activities would be advantageous.

Summary of findings

People received their medicines from staff who were trained to administer them safely. However medicines were not always safely secured and there was not always appropriate guidance

about how people should have their medicines.

Staff were well supported by the manager and received regular training and support. There was an adequate induction programme and effective recruitment process so only suitable staff were employed.

The manager had an effective complaints procedure and involved people in decision making.

People's health care needs were monitored and risks to people's safety were reduced as far as possible. Staff knew what actions they should take if they suspected a person to be at risk of harm or abuse and how to promote people's safety.

The Care Quality Commission (CQC) is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. The provider, manager and staff had an understanding of their responsibilities and processes of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. The manager had a good understanding of the MCA and DOLS and was acting lawfully.

The manager was highly thought of and often provided direct care to people. However we were not assured that the audit processes were sufficiently robust as we identified issues with cleanliness, maintenance and a number of care practices and care records which had not always been identified by the provider.

We found a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we have told the provider to take at the back of the full version of this report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires improvement

The service was mostly safe.

Staff were trained appropriately to give medicines safely but medicines were not always held securely and there were not always clear processes as to when medicines should be administered.

Risks to people's health, welfare and safety were adequately documented and steps taken to minimise risks to people.

There were enough staff but there was no information on people's dependency levels as an indicator of how many staffing hours were required. Staff carried out other non- care duties which took them away from care.

Is the service effective?

Good

The service was effective.

Staff had enough knowledge and skills to meet people's needs.

Staff were supported through an initial induction and then regular training and supervision of practice to ensure they had the key competencies and skills.

People were assumed to have capacity and staff supported people with decision making and gained their consent before providing care.

People were appropriately supported to eat and drink enough for their needs but the options were a little restrictive.

People's health care needs were known and staff referred people to the appropriate health care professional if there was a change in a person's needs.

Is the service caring?

Good

The service was caring.

People's independence was encouraged and people received dignified care.

People care preferences were known by staff.

People and their families were able to comment on the care provided to them and this is turn was used to help improve the service if required.

Is the service responsive?

Good

The service was responsive.

Staff knew people well and were responsive to their needs. Care plans documented how people would like to be supported.

Activities were provided to people but not often enough.

Summary of findings

The provider had a complaints procedure and actively engaged with people asking for them to feedback in terms of the quality of the service.

Is the service well-led?

Requires improvement

The service was not always well- led.

There were some maintenance issues and remedial works had not been carried out.

There were not robust audits in place to identify if cleaning and maintenance was being carried out adequately and we found some examples of where it was not.

There were no recorded audits of care or written handovers so it was difficult to see how staff identified and responded to people's changes needs.

The home did have a quality assurance tool they used to help to collect and record people's experiences of the service to help inform and shape the care they were provided with.

Oaklands Care Home Limited

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.

The inspection took place on the 19 October 2015 and the inspection was unannounced. The inspection was carried out by an inspector and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. Their area of expertise was older people/dementia care.

Before the inspection we looked at information we already held about the service such as the previous inspection reports, and notifications which are important events affecting the well- being and, or safety of people using the service the home is required to tell us about by law.

We spoke with a number of visitors and nine people using the service. We looked at three care-plans, and spoke with six staff. This included domestic staff, the deputy manager, the manager, the activities person, and two care staff. We observed the care being provided across the day including lunch time. We looked at records relating to staffing and in relation to the management of the business.

Requires improvement

Is the service safe?

Our findings

One person we spoke to was able to administer their own medicines and they were able to tell us what they took, when and what it was for. Only staff who had been deemed as competent were able to administer medicines. The manager completed annual competency assessments to ensure staff could give medicines safety. They said competency assessments would be repeated if there were any concerns about staff practices. Staff received face to face medication training. We observed staff administering medication and noted that although medication was dispensed in the office and then taken to the person, medicines were often left out and not securely stored. This meant that unattended medicines could be taken by people they were not intended for. We also noted one person had a tablet next to them. When we asked they said they were going to take it later. This person had been assessed as being able to take their own medication and a risk assessment was in place. They had also been provided with a secure facility to store their medicines. However the person was sitting next to other people so there was a risk that they could take the tablet as it was just loose on the table.

People's medication records were in sufficient detail. However we noted for several people their medicines were crushed and we were told this had been agreed by the GP and recorded on the medication recording sheet. There was nothing recorded in their care plan about this or evidence that this had been authorised by the GP. This could present a risk as crushed medicines absorb differently and some manufacturers state their medicine cannot be crushed. In another instance a person had been administered medication to help with their anxiety/ agitation but there was no protocol in place to inform staff as to why the medicine was prescribed, how it worked and when it would be appropriate for staff to administer it. This meant that staff had to use their own judgement without any thing to guide them. We noted in one month it had been administered five times but we do not know If staff were administering it consistently.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing levels were sufficient to meet people's needs on the day of our inspection. One relative told us "There is always staff about and she, [their relative] always looks good." Staff told us there were enough staff and the manager was always on hand to help.

On the day of our inspection there were two staff providing care to 13 people. In addition the manager was on shift to support staff when they needed it and they told us they were there most days and would come in at different times according to the needs of the home at the time. There was also a person providing activities. They were there for two hours three days a week recently reduced to two days a week. The manager did not have a tool to calculate how many staffing hours they required according to people's dependency levels. They told us they were responsive to changes in people's needs and staffed the home accordingly. We noted there were staff who specifically did the cleaning in the home and another member of staff who came in across the day to help out but this was mainly to help out with domestic type activities. Cooking was undertaken by care staff which reduced the number of care hours provided. The number of 'activity' hours had not been reviewed and a number of people told us there was not enough for them to do during the day. We found no negative impact on people but staffing arrangements would benefit from review to ensure they were adequate to people's needs and well-being.

We met with a number of visitors and asked them if they felt their relatives were well cared for and safe. One relative told us, "If [my relative] is happy then I am happy. They get good care and the staff are very friendly. I have had family in this home previously. There is always staff about and she always looks good. Another told us, "I do think they are safe here. They are brilliant with [my relative) and have lots of patience.

Risks to people's safety were well managed. Staff knew people really well and monitored people's needs and were proactive in reporting any concerns or changes. Staff understood how to support people appropriately and how to raise a safeguard if they suspected a person to be at risk of harm or abuse. Staff were aware of external agencies and their role. Staff received appropriate training in safeguarding adults from abuse and their knowledge was refreshed periodically. We noted around the service there was information to help staff and visitors know who to contact should they suspect a person being abused.

Requires improvement

Is the service safe?

We saw from people's records that risks to people's safety were well managed. We looked at people's manual handling requirements and these were well document and included how many staff were required to assist and any considerations or equipment needed. Risks were reviewed so any change in need could be identified and the care plan changed when appropriate to do so. We saw that where people had unintentionally lost weight referrals had been made either to the GP or the dietician and people were prescribed supplements. The frequency of weighing people should be reviewed according to the level of risk identified in terms of unplanned weight loss.

The provider had suitable recruitment processes in place. This helped ensure that only staff who were suitable to work with older people were employed. We looked at two records which showed us necessary checks were in place before employment including references, application- including checkable work history, a criminal records check, photographic identification and proof of eligibility to work in the UK.

Good

Is the service effective?

Our findings

Staff spoken with told us they received the training and support they required for their role. One member of staff told us, “Appraisals are on a regular basis and supervisions are every 6-8 weeks.

I have done all the mandatory training and we have regular updates.” Some staff had specific responsibilities such as medication, nutrition and care plans and there was a key worker system which was an identified person who oversaw the care of the named person they were responsible for.

Staff had received training around the specific needs of people using the service such as dementia training and were able to say how they would deal with people whom had become distressed.

We looked at two staff records and they included information of staff’s induction, both a basic house induction and a nationally recognised induction where staff worked towards a care certificate which covered the core competencies staff needed. Staff records showed evidence of regular training, and opportunities to do enhanced qualifications. They also showed regular support through appraisal, supervision and observation of practice in relation to safe administration of medicines and care practices.

The manager had an understanding of the Mental Capacity Act 2005 and Deprivation of Liberties Safeguards, (DOLS.) They told us they had not made any deprivation of liberty applications for people who were mostly deemed as having capacity and there were no observed restrictions for people. The manager said some families had enduring power of attorney for care and welfare which would suggest that people did need support around decision making. It was not clear from people’s records who had relatives with an active enduring power of attorney and it would be helpful if this was included. One person had an Essex Guardian for finances. The manager had a policy in place in relation to the MCA and it included a flow chart to show actions staff should take if a person needed support with decision making. People’s records showed that people had been consulted about their health and welfare and had consented to treatment and care as appropriate.

In practice staff supported people appropriately with decisions and offered people choices. The manager said staff had received training on the Mental Capacity Act to help them support people appropriately.

Records showed that people’s health care needs were documented and where a change in need was identified staff followed this up with the relevant health care professionals. We spoke with the visiting community matron who told us staff referred any concerns to their team in a timely way. They said staff were knowledgeable about people’s needs and always had the information to hand which assisted the nurses. They also said people received good basic care and high personal care standards were maintained.

We saw from people’s records that they regularly saw the chiropodist and the GP/Nurse as required. Consent for treatment was recorded. Staff told us they worked closely with the mental health services for people with mental health issues. Staff also said they had received training around end of life care and staff were being supported by the district nursing services with end of life care.

We spoke with staff about people’s health care needs and they were sufficiently knowledgeable about people’s needs. The senior told us, “District Nurses, Community Matron, Incontinence Team, Dentist, Hearing People, GP’s, Practice Nurse, Chiropodist all come and the hairdresser once a week."

We spoke with people and visiting relatives about the food and got a varied response. One relative said, “If they, [my relative] does not like the food on offer, they are quite happy to accommodate nothing is too much bother.” However a person using the service told us, “Food is acceptable, usually there is too much food, I don’t know that there is any choice it is the main meal or salad.” One person told us for breakfast they could have, porridge, cereal or toast but no cooked breakfasts or eggs.

We observed lunch and saw that people ate in the lounge/dining room, some sat round a dining room table. Staff assisted people in an appropriate way and most people enjoyed their meal with little wastage. However we did see one isolated incident in which a person was supported in a way which did not promote their dignity. The menu choices were curry or salad, (most people said the liked curry) and we saw little alternative to this although we were told

Good

Is the service effective?

people could choose what they wanted. We felt the menu, which was duplicated every two weeks offered a limited choice of menu options and there was nothing prepared in the fridge. We have

Staff told us "We weigh everyone once a month and anyone with unplanned weight loss we refer them to the dietician." They were able to tell us about people's dietary needs and who required support to ensure they were not unintentionally losing weight and who required supplements and replacement drinks. Fluid charts were not routinely kept unless they had concerns about someone's fluid intake and staff said they regularly pushed fluids, particularly if people had an infection.

Good

Is the service caring?

Our findings

During the day we observed people's care and asked them about their experiences. One person said, "Their patience is wonderful we are lucky to live here." Another said, "I cannot do much for myself so I have to rely on them and on the whole it is as good as it could be." However they also said, "Staff do their best and generally they are gentle you get the odd one who might be impatient this morning they were patient." Whilst observing lunch we saw one person being rushed and staff need to be mindful of this and go at the persons own pace. One relative told us when their family member's health declined and they went into hospital for a short stay staff visited them every day.

Staff interaction was appropriate to people's needs. Whilst assisting people with their manual handling needs care staff gave constant reassurance and kept the person informed of what was going to happen next .They were consistent throughout these processes. We saw another care staff offering assistance and assuring the person the doctor was coming because they had been unwell. We also saw staff delivered care in a kind, patient way and chatted easily to people.

Care plans clearly stated what people could do for themselves and what they needed help with and we saw staff facilitating people's independence and letting them do as much as they could for themselves. For example we saw one person managed their own medicines, another person was in the kitchen being supported by staff. People's records also recognised the person's right to decline care or treatment where they had capacity to make decisions.

People who used the service and their relatives were given opportunities to comment on the care they received and any changes they thought could be made to the service delivery. We could see the actions taken recorded which showed the service was responsive. One relative told us "We have a relatives meeting twice yearly, we had one two months ago and have a suggestions box but any problems I can speak privately in the office it would be a concern and not a complaint."

We spoke with people and their relatives about the care they received and everyone told us the care was good. One staff member told us, "Most of the residents have family and we do have residents meetings and five of the residents would have their say."

Good

Is the service responsive?

Our findings

Some people were complimentary about the service. One person said, “This is a lovely place, the staff are very helpful. I would highly recommend it.”

One person told us there was communion every month. Another person told us, “There is not a lot to join in, mostly we sleep, I like reading, and I cannot hear the TV. I have been out to a restaurant twice recently, once with my daughter and once with another resident and carer. ”

One person was making cards and also knits for the premature babies and they told us that in the small lounge where they sit they have the teletext running on the television as their hearing is poor.

Activities were provided a few hours twice a week. The manager said outside these times staff were expected to support people and ensure they had things to do. Examples of recent activities included: flower arranging, dominoes, and singing. They said they had some participation from the community such as from local school children who came in at Christmas and sang carols and visits from a befriending organisation every six weeks or so and also visits from members of the church. A number of people went out to a local lunch club. We saw a photo board above the dining table in the lounge had pictures of last Christmas but nothing since.

We observed activities in the morning. They included Flower arranging with four people, chatting and inclusive, singsong and then a board game. There was really good interaction but nothing for the rest of the people who chose not to join in the activity.

Rooms were personalised and people were encouraged to do what they wished with their rooms to help them feel more at home. Although this was a small service there was nothing around the home to help people who might be confused to find their way around.

The service had an established complaints procedure. There was also a suggestion box at the main entrance for people to feedback anonymously if they wished. The manager told us about one complaint and how they were addressing it. They demonstrated they were responsive in dealing with concerns.

Care plans were informative and gave us information about people’s needs and how staff should meet them. There was a list of people’s medicines and what they were for and any possible side effects. There was information about people’s health care needs. Care plans included details about people’s preferred care preferences and routines and also information about people’s psychological needs. One person’s behaviour was under investigation and staff were keeping a record of their behaviour to help develop a greater understanding of their needs and strategies to support them. For other people there was limited information recorded as to how staff should support people with their anxiety or behaviour which might put them or others at risk. We also noted that factors like a urine infection might increase a person’s level of need/risk but there was no short term care plan in place highlighting the increased risk. Staff told us any information and, or changes to people’s needs was verbally handed over from shift to shift but this was not recorded so we were unable to see how robust this process was.

Some of the care records did not have enough information about people’s night routines and care needs so it was difficult to assess if people got the care they needed throughout the night and according to their wishes

Requires improvement

Is the service well-led?

Our findings

We were not assured that the service was safe for people who used it. We therefore concluded the home was not always well managed. There were a number of remedial actions required in terms of the safety of the premises. This included remedial works required to the gas boiler. The boiler had been deemed safe to use but some actions were required. A warning notice had been served by the gas safety engineer as remedial actions had not been completed in a timely way. We saw reports for 2013-14. Remedial works were also due for the electrical wiring which had been prioritised over the boiler works. There was no immediate plan to do all the remedial works required. The environmental health authority had awarded the service three stars for their kitchen and the manager assured us they had revamped the kitchen and replaced units and work surfaces so they were now compliant with food safety. We looked in the kitchen and this was in a good state of repair. However we found uncovered, undated food in the fridge which could pose a risk to people.

We identified problems with the cleanliness of the service and felt this was due to insufficient clinical oversight. The home itself was clean and there were no odours. However we felt the cleaning was superficial and identified some longer standing issues like a build -up of lime scale and some equipment not being clean. There were domestic staff who worked six days a week. They kept records of what they did. However the records were in insufficient detail and there was no evidence that infection control audits were completed regularly. The last infection control audit was April 2015 and did not identify any issues. A recent inspection to test water supplies, for legionnaire's disease highlighted the build-up of lime scale but this had not already been addressed. Carpets were worn and not all equipment was well maintained. For example we identified a frayed sling, and when we brought it to the manager/ providers attention they told us they had plenty of slings staff could use.

We considered this a breach of Regulation 15, Premises and equipment.

The provider had regular, (some weekly) checks on fire systems, alarms, and equipment and regular fire drills.

The manager told us they had enough staff and staff had worked with her for many years and were therefore familiar with people's needs and routines. They did not have a tool to assess people's dependency but said staff would be provided according to people's needs. However during our visit we saw that opportunities for social activity were somewhat limited and there was no cook in post which meant care staff had to do this in addition to care duties. The menus were limited and we felt that people did not always have ample choices possibly because care staff did not have chance to prepare lots of different choices.

Care plans sometimes contained information which was contradictory and there was no evidence that record audits were carried out. For example one person's record said they had given their recorded consent for treatment but on the other hand had been assessed as lacking capacity. It could be that their needs had changed over a period of time. There was additional information to state the person's needs would be discussed with family but there was no evidence if they had enduring power of attorney for the person. An audit would have found this contradiction and potentially resolved matters. Audits of care were not recorded and we identified areas of practice which could be improved and would help us clarify if people's needs were being fully met. A written handover would show us how staff were identifying changes in people's needs and how people received continuity of care with each changeover of staff. Lunch time and social activities could be more robust to ensure people had more personalised care which matched their experiences and wishes.

The registered manager was also the registered owner. Everyone we spoke with felt well supported by the manager and felt that were responsive and worked well as a cohesive team.

They said they had a static staff team and shared ideas to help make sure the service they provided was as good as it could be. They said they did not use agency staff. The manager was a qualified nurse and had lots of relevant experience. They had registered with FANS, friends and neighbours scheme. They were aware of other initiatives being run through the Local Authority but had not registered for anything else which might have provided them with some additional support. They told us they used a compliance management system for key areas of their business including health and safety, human resources and care planning, which gave guidance, templates and audit tools.

Requires improvement

Is the service well-led?

The manager told us they did have robust quality assurance systems, including surveys given out to relatives, health care professionals and people using the service. This was repeated every six months. We saw where concerns had been identified there was a record of what and how this was being addressed. Relatives confirmed there were meetings but these were not held very frequently. The feedback of actions taken was not always robust. For example one person said they wanted more choices and the response was to offer 'sandwiches,' without further exploration of what the person might wish to have.

We saw a number of statutory notifications and the manager knew what she needed to report to us.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010 Safety and suitability of premises **The provider had not ensured the premises and equipment was clean, and properly maintained.** Regulation 15 (1) (a) (e)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **The provider had not ensured medicine practices were sufficiently robust.** Regulation 12 (2) (g)

This section is primarily information for the provider

Enforcement actions

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