Care Quality Commission

Oak Mount Care Home Limited

Oak Mount Care Home

Inspection report

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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?	Good
Is the service responsive?	Requires improvement
Is the service well-led?	Requires improvement

Overall summary

This was an unannounced, comprehensive inspection on 18 and 19 May 2015. Two inspectors visited the home on both days.

Oak Mount Care Home is registered to provide accommodation, personal care and support for up to 21 people. The home does not provide nursing care. At the time of the inspection there were 20 people living there.

The registered manager had been employed since August 2014. 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.'

The inspection was carried out in response to information of concern.

The feedback we received from people and their relatives and visitors was that Oak Mount Care Home was a caring and well run home. People told us that staff were kind and helpful. One person told us, "The staff are super, they'll do anything for you and they come quickly if you need them". Others told us that they felt respected and supported to live their life in the home as they wished.

Summary of findings

We found a number of breaches of the Health and Social Care Regulations 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.

Risks to people's health were not safely managed because systems to prevent and manage infections were not robust. Neither the provider, registered manager nor staff had recognised that a lack of hand washing facilities was an infection control risk and there were issues regarding the supply of hot water in various parts of the home.

Systems to manage the administration of people's medicines were robust and meant that people received their medicines as they were prescribed. We could not be sure that people always received all of the food and fluids they needed to maintain good health.

We observed that there were times when staff were rushed and had a number of other tasks to complete in addition to their caring duties. This meant that some people's care was task focussed rather than person centred.

The layout of the building meant that it cannot always meet the needs of people if they increase during their stay, especially with regard to mobility. The registered manager was aware of this and told us they discussed this issue with people prior to moving into the home or as and when their care needs increased.

Staff received regular supervision and training and were knowledgeable about their roles and responsibilities. They had the skills to help people with their care and support needs.

Some assessments of people's needs had not recognised specific care needs such as the management of diabetes or behaviour that challenges others. This meant that there was no guidance for staff to refer to if they needed it in these areas.

Observations and feedback from the staff, relatives and professionals showed us that the home had an open and caring culture.

The management structure of the home was clear. People told us that they knew how to make complaints and found the registered manager and provider approachable. Systems to monitor the safety and quality of the service required improvement.

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 not always safe.

Improvements were needed in the systems for the prevention and management of infections.

Medicines were safely managed and administered. There was a good understanding of safeguarding adults which was put into practice to protect people.

There were mixed views with regard to staffing deployment and levels. The registered manager will review these.

Is the service effective?

Requires improvement

Improvements were needed to ensure that the service was always effective.

People may not always be supported to eat and drink enough to meet their needs.

Some items of furniture may not meet people's needs. A review of furniture in the home is to be undertaken.

Staff had received a good level of training and told us they felt supported in their roles.

People's rights were protected because their consent was properly obtained and the protections for people under the Mental Capacity Act 2005 had been implemented.

Is the service caring?

Good

The service was caring

People and their relatives told us that staff were kind and caring.

Staff had a good understanding of each person, their needs and how they liked to be cared for.

People were consulted about what they would like to do, offered choices and were respected.

Is the service responsive?

Requires improvement

The service was not consistently responsive.

People were at risk of their needs not being met because assessments were not robust and care plans had not been created for some care needs.

The service had a complaints policy and people told us they felt able to speak out if they had any concerns.

Summary of findings

Is the service well-led?

The service was not always well-led.

Quality monitoring systems had not been fully implemented and audit systems were not robust.

There were omissions and errors in records.

Oak Mount had a homely, relaxed atmosphere with an open and positive culture.

People said they felt included in the day to day running of the home and would feel able to raise concerns if they had any.

Requires improvement

Oak Mount Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked whether the provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 18 and 19 May 2015 and was unannounced. There were two inspectors present throughout the inspection. During our inspection we met and spoke with most of the people living in the home, four visiting relatives, one of the company directors, the registered manager, eight members of staff and five visiting health professionals. Because some people were living with dementia, we used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

We did not ask the provider to complete a Provider Information Return (PIR) before our inspection. This is a form that asks the provider to give some key information about the service, what the service does well and what improvements they planned to make. This was because we brought the inspection forward following information we received. We reviewed the information we held about the home, which included notifications the service is required to make.

We observed how people were supported and looked at three people's care and support records, an additional five people's care monitoring records and medication administration records and documents about how the service was managed. This included four staffing records, audits, meeting minutes, training records, maintenance records and quality assurance records.

Requires improvement

Is the service safe?

Our findings

People told us they felt settled and comfortable. One person said, "The staff are super, they'll do anything for you and they come quickly if you need them". The relatives we chatted to all confirmed that they felt their relatives were safe at Oak Mount Care Home. One relative told us, "We are very impressed with Oak Mount. Dad didn't settle in a previous place. He is very opinionated but has settled well here and seems happy".

However, we found that appropriate steps had not always been taken to keep people safe and to protect them from the risks of infection.

During the previous six months there had been two outbreaks of infection amongst the people living in the home and some staff. We looked at the measures that were in place to control this once it was identified. Care staff confirmed that they undertook additional cleaning with appropriate products and wore disposable gloves and aprons. All of the staff except the chef had undertaken infection prevention and control training within the last twelve months.

There were no facilities for staff or visitors to wash and dry their hands in people's ensuite facilities or bedrooms. Additionally, there was a communal towel in the first floor bathroom and WC because the hand drier was broken. One of the visiting health professionals also raised the difficulty with hand washing with us. The provider's infection control policy stated that staff must wash their hands and "Thoroughly dry with paper towel".

The kitchen was more of a domestic than commercial type and was showing signs of wear and tear. Some parts of the cooker controls had broken, were greasy and sticky and had not been properly cleaned. We were concerned that the poor condition of the cooker may harbour bacteria which could cause infection.

These shortfalls in the assessing of the risk of, preventing, and controlling the spread of infections were a breach of Regulation 12(2)(h) d the Health and Social Care Regulations 2008 (Regulated Activities) Regulations 2014.

Medicines were safely stored and disposed of appropriately. We checked a sample of medicines and found that stock tallied with the records completed. One person was having their medicines administered covertly; this meant that the person was not aware that they were taking medicines because it was in either their drink or their food. The home's policy for covert medication had been followed. They had considered whether the person had the capacity to make the decision about taking medicines, whether the decision to administer covertly was being made in their best interest and had consulted the people that needed to be involved about the decision.

The registered manager confirmed that they had identified some administration errors since their appointment in August 2014 and had therefore reviewed the systems for administering medicines. We saw that times of administration rounds had been reviewed and altered, following consultation with GPs, to better reflect people's daily routines and to allow care staff more time to undertake the task. The care staff giving medicines also wore a red tabard to indicate that they should not be disturbed. Staff took medicines to people and provided them with drinks to help them take their medicines. They were patient, did not rush people and were able to remind people what their medicines were for if they were asked.

Staff demonstrated a good level of knowledge about the safe administration of medicines and records showed that all care staff had completed training and had their competency assessed within the last 12 months.

The registered manager confirmed that the incidence of errors had decreased and that they continued to carry out regular audits to ensure systems continued to be effective.

Most people said that there were enough staff most of the time. However, some of the visiting relatives and health professionals told us that they felt that staffing levels were satisfactory but they were concerned that staff often seemed rushed. We also received concerns that staffing levels, particularly at night, were insufficient to provide adequate care and support. Staff had mixed views about their work loads. Most felt they needed to spend more time providing people's care but found that they spent too much time carrying out other tasks such as managing the laundry, carrying hot water to rooms, preparing food and drinks after 4pm, and domestic tasks. They said they made sure that people received the care they needed but they felt that it was rushed and could be done better if they had more time. We looked at the rotas for the week of the inspection and the week preceding this. The rotas reflected the levels of staff on duty throughout the two days of our inspection. Staff pointed out to us that on weekday

Requires improvement

Is the service safe?

mornings, the rota showed there was a senior staff and two staff on duty. The staffing plan was that the senior staff would perform care duties until 1.30pm. However, staff told us that often the senior staff were called away to assist GP's or other health professionals or to make telephone calls which meant there were often only two staff to help people. The registered manager showed us that, following a review of work loads, the shift patterns had been amended to increase the number of care staff working at the busier parts of the day. We discussed the issues that we had found and they agreed to carry out further analysis.

We recommend that a review of staffing levels is undertaken in light of the issues raised during this inspection.

Records of accidents and incidents contained details of 36 falls between 1 January 2015 and 19 May 2015. The registered manager had carried out audits to establish whether people had fallen frequently. Where this was the case, the registered manager had reviewed the person's falls risk assessment and had investigated whether this was due to a medical condition or environmental factor. They had also sought support from the local NHS falls clinic. The audits did not show that the times or locations of the falls had been considered. Twenty eight (77%) of the falls had occurred in people's bedrooms, 23 (63%) had occurred between 8pm and 8am, and 30 (83%) had been unwitnessed. Four of the falls had resulted in fractures.

We recommend that consideration of the times and locations of accidents is included as part of the audit process as it appears there may be an unrecognised pattern to many of the accidents.

There was a system in place to ensure that risks to people were assessed and plans were implemented to reduce risks. Risk assessments were in place for areas such as the risk of falls, moving and handling, malnutrition and pressure area care. There were also assessments for people who wished to smoke. Risk assessments were reviewed whenever the person's needs changed or monthly if there had been no significant change in need.

There were satisfactory arrangements in place to ensure that there were regular checks of the building and equipment. Assessments of the property and possible risks had also been carried out. This included a fire and legionella risk assessment and also use of equipment such as the stair lift. Maintenance contracts were in place for items such as the stair lift and fire warning system and there were up-to-date certificates for safety checks on the gas and electrical system.

There were satisfactory plans in place for the continued care of people in the event of an emergency. Regular checks were made of the fire warning system, hot water system and general maintenance of the home. However the systems in place to monitor the risks to people and staff were not always effective. A number of rooms did not have hot water and so care staff were carrying buckets of hot water to the rooms when people needed personal care. Despite the regular checks that had been carried out, the provider stated that they had thought this problem had been solved and was not aware that staff were doing this.

The shortfall in the provision of hot water was a breach of Regulation 12(2)(d) of the Health and Social Care Regulations 2008 (Regulated Activities) Regulations 2014

Satisfactory recruitment procedures were in place. The required checks were undertaken before staff started work and records contained proof of identity, including a recent photograph, and the other information which is required by the Regulations.

Training records showed that all except three of the staff had undertaken training in safeguarding adults and recognising abuse within the last 12 months. Staff were knowledgeable about spotting possible signs of abuse and the reporting processes they should follow if they suspected abuse had occurred. The provider's safeguarding policy was up to date and gave the required guidance. The registered manager's notifications to the Commission showed the registered manager appropriately referred concerns reported by staff to the local safeguarding authority.

Requires improvement

Is the service effective?

Our findings

People told us they felt supported to live their lives as they wished and that there was always help available if they needed it. Relatives told us that staff were quick to seek advice from GPs or other health professionals. However, we identified some shortfalls that could have adverse effects on some people.

People who were at risk of malnutrition had their food and fluid intake and weight monitored. However, we could not be sure that people were receiving all of the fluids and food they needed and that records were accurate. Some people's fluid charts had a target for fluid intake that was generic and did not take into account the person's individual needs. Other charts did not have a target amount. This meant staff were not always easily able to identify whether people had received enough fluid to prevent them becoming dehydrated. Fluid charts recorded two amounts: the amount offered and the amount actually drunk. Totals on the charts were the totals of the amount offered to people and not the amount they had drunk. Analysis of charts over the previous three days showed that one person had been offered 63% of the target fluid intake but had only drunk 50% of their target. Another person had been offered 78% of the target fluid intake but had only drunk 57% of their target. In some cases, night staff had recorded in other records that they had provided drinks for people but these had not been added to the fluid charts. Food charts did not have enough information to show that people who were at risk of malnutrition had eaten a sufficient amount. There was no information in care plans about what to do if people failed to take sufficient food and fluid and there were no entries in daily records about any action that had been taken to encourage people to try to improve the amount of food and fluid people consumed.

These shortfalls in assessing, planning and meeting people's nutrition and hydration needs were a breach of Regulation 9(3)(i) of the Health and Social Care Regulations 2008 (Regulated Activities) Regulations 2014.

Oak Mount has been a care home for over 20 years. During this time the building has been adapted and extended to increase the number of beds, provide some ensuite facilities and improve the communal areas. Many of the adaptations to the building have resulted in steps being added, such as a step into some bedrooms, a step in part of the dining area and restricted access to the first floor as there was only a stair lift. This meant that parts of the home may not be accessible to people with poor mobility.

There was a well laid out, secure back garden but a number of steps had to be negotiated to get to it. Access to the main entrance of the home was up a steep drive that had an uneven surface. The provider advised that there were plans to improve access to the gardens, that all visitors were told they could drive up to the front door when collecting or returning people to the home and that people were advised on admission of the restrictions that the different floor levels in the home may place on some people. The registered manager also advised that they had recently reassessed a number of people who had been living in the home because their needs had increased beyond that which they could provide within the constraints of the building.

Some rooms were narrow which meant that the amount of furniture that could be fitted in was restricted. All of the rooms had an armchair but some of these were small with a low back and did not offer full back support for people to relax in. One person told us they were waiting for the provider to provide a different chair. The registered manager and some of the staff agreed that armchairs similar to those in the communal areas would be more appropriate. The registered manager agreed to investigate whether people would prefer different chairs in their rooms.

Most people had ordinary divan beds. There was one bed that was adjustable and provided better support and management for people with greater needs. Health professionals told us that some people may benefit from more specialist beds. They said they had told staff about this but the registered manager said they had not been informed. They agreed to investigate this immediately.

We recommend that a review of the furniture and equipment provided for people is carried out to ensure that they have the required items to meet their needs.

The chef confirmed they were aware of people's dietary requirements, such as for a high calorie or diabetic diet and also of people's likes and dislikes. Staff told us there was a

Requires improvement

Is the service effective?

choice of cereals, toast and other items for breakfast, lunch with choices for each course and an evening meal that also had a number of choices. We were told that drinks and snacks were available at all times.

We observed lunchtime on both days. Staff served meals to people individually and adjusted portion sizes either due to people's requests or because they knew how much each person was likely to eat. Meals smelled appetising and looked attractive. All of the people we spoke with told us they enjoyed the meals. Staff were on hand to encourage people to eat and drink; they were offered choices of drinks as well as assistance with condiments such as salt, pepper and sauces. Where people expressed a dislike, staff immediately sought an alternative from the kitchen.

Various health professionals including GPs, district nurses and mental health staff visited the home during the inspection. They confirmed that the home always sought advice and support appropriately and that staff acted on any instructions that were given meaning that people received the health care that they needed.

Staff told us they also had training provided which had increased their knowledge and understanding and therefore enabled them to improve the care they provided. Detailed induction training was provided in line with national standards. Regular refresher training in essential areas such as moving and handling, safeguarding adults and health and safety were provided and staff were also encouraged and supported to undertake additional training. Thirteen of the 18 staff had achieved or were studying level 2 or level 3 of a national level qualification in health and social care. An external trainer was in the home during the inspection. They confirmed the home supported staff with training and that the staff group all "really liked to learn".

Staff confirmed they received support and supervision from the registered manager or head of care. The registered manager acknowledged that, due to the changes in management, the frequency of supervision was not in line with the home's policy and confirmed that a plan was in place to address this.

The Care Quality Commission monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. The registered manager understood when an application should be made and how to submit one and was aware of a 2014 Supreme Court Judgement that widened and clarified the definition of a deprivation of liberty. Applications had been submitted to the relevant local authority for a number of people and the home were waiting for assessments to be carried out. We found the home to be meeting the requirements of the Deprivation of Liberty Safeguards

Where people lacked the mental capacity to make decisions the home was guided by the principles of the Mental Capacity Act 2005 to ensure any decisions were made in the person's best interests. There were mental capacity assessments and best interests decision making records in people's individual care records to support this.

Good

Is the service caring?

Our findings

People and their families told us they felt respected and involved in the life of the home. Visitors told us they were always made welcome. People said the staff were always friendly and ready to help even if they were busy. One person commented that one of the staff "often has my (walking) frame ready for me before I even ask for it!".

An armchair exercise class was taking place in the lounge when we arrived. A visiting instructor led the class and staff were supporting people. There was lots of chat and laughter and the class was well attended. Some people did not want to take part in the exercises but were encouraged by staff to stay and watch. Some people then joined in with the exercises and others chatted whilst they watched.

Staff had a good understanding of each person, their needs and how they liked to be cared for. They knew how to reassure and calm people if they became agitated and also had a good knowledge of each person's life history, which meant that they could connect with people and have meaningful conversations.

People's individual care files reflected that staff had tried to obtain information about their lives before they moved to Oak Mount. This included information about family and friends and past occupations. The registered manager told us that they were in the process of introducing a document called 'This is me', which would provide staff with a summary of each person, what they had done in their life, meaningful people and relationships and their achievements as well as how they liked to spend their day, likes and dislikes and other personalised information. This was aimed at making people's care even more personalised.

There were good interactions between people and staff. Staff had a friendly manner and were patient and respectful. Most people needed assistance to move from room to room. Staff walked at the pace of the person and did not rush them and chatted with people whilst supporting them. This made the support person-centred rather than task based.

Throughout the inspection staff consulted people about what they would like to do, offered choices and responded to requests. People and visitors confirmed they were consulted about their care needs and how they wanted them to be met and were aware of care plans and reviews. The registered manager confirmed they knew how to access advocacy services should anyone in the home require such support.

People's privacy and dignity was respected. Staff told us how they used blankets and towels to keep people covered as much as possible whilst they were providing personal care. We observed that bedroom doors were always closed when staff were assisting people and staff also told us they were careful to close curtains as well if the time of day or location of the room meant that people's privacy may be compromised.

Requires improvement

Is the service responsive?

Our findings

People told us that their care needs were met and that staff listened and responded to them. Visitors said they felt able to contact the home if they had queries and that staff kept them up to date with any changes in their relative's health or care needs. One person told us how they had had a craving for devilled kidneys. The staff told the chef and the meal was provided, much to the person's delight.

During the inspection we heard call bells ringing and observed that staff were quick to respond to them. People told us that they sometimes had to wait a while when they rang the bell but this would be because staff were already busy helping other people.

Each person had a care plan. The care plans showed that people's needs had been assessed and care had, to some extent, been planned to meet their needs. Risk assessments were also completed. Care plans were reviewed following any change of need or every month if there had been no changes. Some care plans lacked detail, which meant staff may not have important information about how to meet particular needs. For example, some people had diabetes and others could display behaviour that was challenging to others. Care plans did not contain information about how the staff should support this person to manage their diabetes or the possible risks and complications relating to this condition. Similarly, charts were being completed to record any behaviour that was challenging. There were no guidelines about the type of information to record, no analysis of events to identify possible triggers and, whilst staff had developed many ways to try to help the person and prevent incidents, there was very little information about this recorded in the care plan.

These shortfalls in the accurately assessing, planning and meeting people's care needs were a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was an activities diary on a noticeboard in the dining room. This showed an organised activity at least once each day from Monday to Friday. The registered manager explained that there were no activities planned over weekends as so many of the people living in the home either received visitors or went out with family and friends. The activities for the week of the inspection included quizzes, a mobile clothes shop, an entertainer and an exercise class. People told us that there were newspapers available and that they also had films and television programmes to watch. One person had previously enjoyed sewing tapestries and the staff had encouraged them to start doing this again. Another person liked to go shopping once a week and a schedule had been drawn up to ensure that a member of staff was available to escort the person.

There was a complaints leaflet available in the main entrance. Details about how to complain were also included in the information given to people when they moved to the home. The leaflet clearly set out how a complaint could be made and the response that should be expected regarding investigation processes and timescales. Records for complaints contained information about the investigation, outcome and any action taken to ensure that any learning or improvements as a result of the investigation were made.

Requires improvement

Is the service well-led?

Our findings

People and visitors told us the provider and registered manager were approachable and listened to them if they needed to discuss anything. They said they did not have any concerns about the running of the home but would feel confident to speak up should the need arise.

Systems to monitor the quality of the service and drive forward improvements required improvement. This was because audits of the medication system had identified failures but problems were still occurring despite changes to the system. A further evaluation had not been carried out. An audit of falls in the home had not identified that there may be contributing factors such as the time and location of the fall or the impact of staffing levels. Other audits were being developed but had not been implemented. An audit of infection prevention and control in the home had not been undertaken even though there had been two infectious disease outbreaks within the last six months.

These shortfalls in assessing and monitoring the quality and safety of the service were a breach of Regulation 17(2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Some records relating to people's care and to management of medicines lacked detail or were incomplete. For example, food records did not clearly show what people had eaten or the quantity. Medicine administration records did not always record when staff had applied people's prescribed creams.

The shortfalls record keeping were a breach of Regulation 17(2) (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Observations during our inspection and feedback from people living in the home, visitors and staff showed us the home had a positive and caring culture. This was because there were regular opportunities for people to contribute to its day to day running through informal discussions, resident and relatives meetings, and regular surveys of people living in the home, relatives and health professionals.

Staff told us they felt supported and able to raise concerns should they have any. We saw confirmation of this in the investigation of an incident that staff had told the registered manager about. Staff had regular supervision sessions and staff meetings. Records of these meetings were available in a communication folder where the registered manager placed important information for staff to read at the beginning of each shift.

Staff knew how to raise concerns and were aware of whistleblowing policies and processes. Although policies had been regularly reviewed some were incomplete or lacking detail. For example, the whistleblowing policy did not have the contact details of the local authority or The Commission. Some policies had been created to comply with previous regulations and standards, which had been superseded in October 2014. The registered manager told us that they had identified this and were working to update all policies and procedures.

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 12 HSCA (RA) Regulations 2014 Safe care and treatment **People were not protected against the risks of infections.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **Hot water was not provided throughout the building in a safe way.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care **People were not protected against the risks of inadequate nutrition and hydration.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care **People's needs were not accurately assessed and planned for.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance **Systems to identify where quality or safety were being compromised and were not robust.**

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance People were not protected against the risks of unsafe or inappropriate care because accurate records had not been maintained.

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.