

Anchor Carehomes Limited

Oakwood Grange

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?

Requires Improvement ●

Is the service responsive?

Requires Improvement ●

Is the service well-led?

Requires Improvement ●

Summary of findings

Overall summary

The inspection took place on 5 and 20 September 2016. The inspection was unannounced on both days. The home had not been inspected since it had been taken over by Anchor Care Homes in September 2015. We carried out this inspection as we had received information of concern about the quality of the care at the home.

Oakwood Grange is a home which offers accommodation to up to 60 older people and people living with dementia. Accommodation is offered over two floors and does not include any nursing care. There was no registered manager in post at the time of our inspection. The manager who had been in post since April was absent from the home at the time of the inspection. The day to day running of the home was being carried out by two peripatetic managers on both of the days we visited the home.

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

There had been a fire risk assessment carried out which had identified areas of risk which needed to be addressed. We found there were multiple areas which had been identified as high risk which had not been actioned. This meant the building may not be safe in the event of fire.

There were no personal emergency evacuation plans in place which instructed staff how they should assist people to leave the building safely in the event of an emergency.

We found medicines were stored, administered and managed safely and people received their medicines as prescribed.

Staff undertook regular training to ensure they had the relevant skills and knowledge to carry out their roles. Staff were knowledgeable about all aspects of the training they had undertaken when we spoke with them.

Mental capacity assessments, best interest decisions and Deprivation of Liberty Safeguards were not in place for all people who required them. There was little evidence that people had been asked for or given their consent for the care they were receiving.

Despite the home having a 'dementia unit' we found the environment was not adapted to meet the needs of people who were living with dementia.

Staff were kind, caring and patient when supporting people. There were positive relationships evident and staff gave thought to maintaining the privacy and dignity of people they were supporting. Staff encouraged people to be as independent as they were able.

Care plans were not always person centred and some did not contain all the information required for staff to meet people's needs.

There was a programme of activities within the home, which included entertainers and other arranged activities including exercise classes.

The home had several managers over a short timescale, which had left staff feeling unsettled, although staff reported an improvement over recent weeks since the peripatetic managers had been supporting the home.

Monitoring and auditing processes were confused and as a result were not consistent or efficient. This had led to a lack of oversight and concerns about the safety and quality of the care within the home. However these issues had been recognised and action was already being taken by the time of the inspection.

We found the registered provider was in breach of two regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, in relation to the safety of the building and the need for consent. You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not always safe.

We saw there had been a check carried out which had identified areas of concern in relation to the safety of the building in the event of fire. There were a number of actions which had been classified as High risk; these had not been actioned to ensure the safety of people in the home.

There were no personal emergency action plans in place to instruct staff how to assist people safely from the building in the event of an emergency.

Medicines were managed safely and there were sufficient staff on duty to meet people's needs safely.

Requires Improvement ●

Is the service effective?

The service was not always effective.

Staff appeared knowledgeable and competent, with the skills they needed to carry out their roles.

Mental Capacity assessments had not been carried out to identify whether people had capacity to make specific decisions. There had not been appropriate referrals made to the local authority in all cases where people were being deprived of their liberty to ensure this was in their best interest and legal.

We saw the home advertised as being a 'dementia specialist home'; however we found the environment was not adapted to the needs of people living with dementia.

Requires Improvement ●

Is the service caring?

The service was not always caring.

Staff were kind, caring and considerate. We saw there were positive relationships and interactions within the home.

We received positive feedback from people we spoke with and

Requires Improvement ●

their relatives about the standard of care and support.

People were encouraged to be independent and to what they could for themselves.

Is the service responsive?

The service was not always responsive.

There were some elements of care plans which were person centred, however they lacked detail about people's lives and preferences.

There were some sections of care plans which had not been completed which meant information was missing in relation to some elements of people's needs being met.

There were activities taking place in the home, and the home invited various outside entertainers into the home for example singers and exercise classes.

Requires Improvement 

Is the service well-led?

The service was not well-led.

The home had a number of managers over a short period, which had led to a lack of consistency and monitoring of the quality and safety of the home. The registered provider had not ensured they had oversight of the home to ensure standards were maintained.

Monitoring and auditing processes were confused and were a mixture of old and new systems. The registered provider had identified a large number of issues in the home prior to our inspection and had created an action plan to show what they were doing to address these matters.

Records were not of a good standard, and we found there were issues with confidential records being left around the home and in unsecured cabinets in areas of the home which were not supervised at all times.

Requires Improvement 

Oakwood Grange

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 inspection took place on 5 and 20 September 2016 and was unannounced on both days. The inspection was carried out by one adult social care inspector on the first day and two adult social care inspectors on the second day.

Prior to the inspection we gathered and reviewed the information we held about the service, which included notifications of significant events which had been submitted to us and feedback from other agencies who work with the home including local authority commissioners.

During the inspection we reviewed the care records for six people who used the service, which included daily care records and risk assessments. We looked at the medication records which were kept, accident and incident records, policy and procedures, safety certificates for the building and the monitoring and auditing processes which had been carried out over the last 12 months. We also looked at the current action plans which had been created.

We observed people and staff and the interactions which were taking place. We also spoke with the head of care, two peripatetic managers, one of the deputy managers, two catering staff and five care staff. We spoke with eight people who lived at the home and four relatives who were visiting during the inspection. We also carried out an observation of people on the second day of the inspection under a short observational framework (SOFI) which allowed us to gain information about the care and support people who we were not able to speak with were receiving.

Is the service safe?

Our findings

People told us they felt safe in the home, one person said, "I feel safe here, and there are enough staff around." Relatives we spoke with told us they felt their relatives were safe and well cared for.

Staff we spoke with had undertaken safeguarding training and were able to explain the types of abuse and how they would recognise signs which may indicate there was abuse taking place. Staff were clear about the processes they needed to follow to report any concerns they may have and understood their role and responsibility in keeping people safe.

We looked at the risk assessments which were in place in people's care plans. We found there were individual risk assessments to look at different areas of risk, for example there were falls risk assessments, skin integrity risk assessments and nutritional risk assessments. We found that whilst the assessments had been completed the information and scoring was not always accurate. For instance we found in one case the assessment which was carried out to identify the level of risk from pressure damage was underscored by five points as a section had been missed during scoring which increased the score from 12 to 17. This meant the person's care may not be safely planned to meet their needs. In another instance we found the person's body mass index (BMI) was incorrectly calculated as the chart which was in place did not allow for their height and they were being scored based on being significantly taller (seven inches), which meant they were showing a very low BMI when in fact they were within normal limits when the calculation was amended.

We found there had been a fire risk assessment carried out on the building 18 January 2016. There had been a report created which identified all non-compliant areas within the building and gave a risk assessment for each item which needed to be addressed. There was evidence that some of the actions which were low and medium risk had been rectified, however items which were high risk had not been completed. The items which were rated as high risk included poorly fitting fire doors which would not serve their purpose correctly, and missing smoke seals for bedroom doors which meant the doors would not resist smoke as they were intended to do.

This was a breach of Regulation 15 of the Health and Social Care Act 2008 (regulated Activities) Regulations 2014.

We looked at other safety checks which had been carried out on the building including gas appliances, lifts and legionella testing and found these to be carried out regularly and the current certificates were valid. We found there had been regular testing of portable appliances (PAT) and equipment which was used to assist people in the home was well maintained and regularly serviced and checked to ensure it was safe to use. We saw there were individual slings in place where people were assisted with a hoist to transfer them from one position to another, which meant the slings were the correct size and type for the individual and that there was no risk of cross contamination from sharing the slings.

We looked at the records which were kept in relation to accidents and incidents which took place in the home. We found there was a file where these were stored. There had recently been a summary sheet

implemented which recorded in an easily accessible list the accident and incidents which had occurred in any month which meant the information could be analysed. This was a new process and analysis had not yet been carried out. The records were detailed and showed where in the home accidents and incidents had taken place and at what time of day or night.

We found there were sufficient staff on duty to safely meet people's needs. There was a dependency tool which was in place, however this did not reflect the numbers of staff on duty and the manager was unable to explain the relevance of the figures which had been calculated. We noted there were very few call bells heard and when call bells were pressed staff responded quickly to them. Feedback from people and their relatives was that staff were attentive and they did not have to wait for attention. One person told us, "It's a brilliant home, there are plenty of staff and they spoil me."

We reviewed the recruitment process which was in place in the home. We looked at the recruitment files for three members of staff. We found the registered provider had carried out all appropriate pre-employment checks, including a disclosure and barring service check (DBS) which allows employers to make safer recruitment decisions.

We looked at how medicines were managed in the home. We found there were processes in place to ensure medicines were stored safely and securely. We observed a member of staff administering medicines, and we found that whilst they ensured the correct medicines were given to each person and they were patient in allowing people time to take their medicines, we were concerned that the member of staff did not wear gloves whilst handling medicines. The member of staff did have clean hands however they should not touch any medicines with bare hands to avoid the risk of absorbing medicines and cross contamination by doing so.

We found the room in which medicines was stored was kept at an appropriate temperature to ensure medicines remained effective. We found the room where medicines were kept and the trolleys which were used from which to administer medicines were tidy and well organised. We found the records which were kept were accurate and did not have any gaps in the signatures. We checked some stocks of medicines against the records which were kept and found these matched.

We found the home to be clean and free from odours. People we spoke with did not express any concerns about the level of cleanliness within the home. We found there were stocks of personal protective equipment available to staff for example there were hand gel dispensers in corridors and gloves and aprons in bathrooms.

Is the service effective?

Our findings

People who lived at the home told us, "It's a very good home, the food is very good" and "I have to tell you, the food is very good."

We looked at the records which showed what training staff had undertaken. This was stored on a training matrix which showed when staff had undertaken training and when the training was due to be refreshed. Staff we spoke with told us and records confirmed staff had undertaken all mandatory training and this was regularly refreshed to ensure their skills and knowledge was kept up to date. Mandatory training includes safe handling of medicines, moving and handling people, emergency aid and health and safety. We saw staff had also undertaken additional training which included dementia awareness, The Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) and managing challenging behaviour. Staff who administered medication had received specialist training from the pharmacist who supplied medicines to the home.

Staff told us and records we reviewed confirmed that staff had regular supervision sessions with senior staff. Supervision is a key element of supporting care staff as it gives them the opportunity to ask questions, develop their knowledge and be reminded of policies and procedures which are in place to ensure the safety of people who live at the home. There was a programme of annual appraisals within the home for staff to review their performance and development.

Staff reported they had not felt supported for a period of several months, however they said this had improved since the peripatetic managers had been involved in the management of the home. Staff told us there had been regular staff meetings over recent months and these were viewed positively by the staff we spoke with. Staff felt they were being listened to and this had improved how staff were feeling following the period of instability they described.

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.

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). We reviewed the records held in respect of DoLS applications and found that whilst there had been significant work carried out there were still a number of people who had been assessed as not having capacity to make their own decisions about where they lived for whom there had not been an application made for an authorisation to deprive them of their liberty.

We reviewed the care records of 6 people who lived at the home, all of whom had a cognitive impairment. We found there was little evidence of mental capacity assessments having been carried out, although there

was information which demonstrated an assessment was needed. We found there had been some applications made for DoLS and there were some people for who a current authorisation was in place. However we found there were a large number of people who had been identified as requiring a DoLS but no application had yet been made.

We saw from people's care records there was no reference to whether anyone held Power of Attorney (POA) or what this covered. It is important that where a POA is in place a copy of the document is held in a person's care records to ensure they are consulted in the decision making process and decisions which are made are done so legally.

We reviewed how consent was being sought and gained from people in the home. We found consent to forms were not signed by people or their representatives, some however had been signed by staff. We did not see that in cases where people did not have capacity to make their own decisions in relation to where they lived or the care they needed that there had been a best interest decision made.

This was a breach of Regulation 11 need for consent of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People we spoke with told us the food was good and they enjoyed the meals they received. People told us they had a choice of foods and if staff knew people liked a particular food they would ensure they had this available to them. One person told us, "They get the things I like, I just let them know" another person said "We get offered plenty to eat and drink, food is good here."

We observed the lunch service during the second day of the inspection and found there had been efforts made to make this a pleasant dining experience as tables were nicely set, staff were attentive and supporting people and there was a choice of food offered to everyone when they were served.

We had identified some issues with people's weight loss during the first day of the inspection which we raised with the head of care. We were contacted by the head of care between the first and second day of the inspection to inform us of the action plan and action which had been taken to address our concerns and ensure appropriate referrals had been made to health professionals. When we returned for the second day of the inspection we found all the actions from the action plan had been completed.

We saw from people's care records there were regular visits to people in the home by a range of health professionals including GPs, District Nurses, opticians and chiropodists. People and their relatives told us staff rang for the GP if there were any concerns about their health straight away.

We noted that despite the home advertising that it had a 'dementia specialist unit' there had been very little adaptation made to the environment to improve the lives of people living with dementia. For example we saw there were some signs which included photographs on people's bedroom doors to help them identify their own rooms, however the corridors were all very similar which would make it difficult for a person living with dementia to find their way around.

Is the service caring?

Our findings

People who used the service told us, "I like it here, staff are nice" and "It's a good place, they're good lasses." A relative told us, "Care staff are very friendly; they keep me informed of what is happening with [relative]."

We observed interactions between staff and people who lived at the home throughout the inspection. We found staff were kind, caring and patient when supporting people. We saw there were positive relationships between staff and people who lived at the home. Relatives we spoke with told us staff were kind and welcomed them when they visited the home.

We spoke with people about their level of involvement in the running of the home and whether they felt they had been kept informed of changes and developments. People and their relatives told us they could not recall there being any meetings held to which they had been invited. We confirmed there had not been any meetings when we asked to see minutes of recent meetings and there were none available. One person told us, "I have never been asked for my opinions."

We found staff were considerate of people's privacy generally and were respectful when approaching people. Staff were discreet in their conversations with people who lived at the home and were careful not to discuss people in areas where they may be overheard.

We observed people were clean and well presented. There was thought given to maintaining people's dignity, for example by ensuring they were covered when being assisted to be moved, and that people had access to their glasses and hearing aids were worn.

We saw and heard staff encouraging people to maintain their independence and to carry out tasks themselves when they were able to do so, for example one person enjoyed helping out with chores and they helped staff with setting tables etc. they told us, "I like to keep busy, I help out with the chores."

We found in the care records we looked at there was no evidence of advocates being used, and we did not speak to anyone who told us they had an advocate to support them to make decisions. An advocate is an independent person who helps people who need support to make decisions and share their thoughts and preferences when they have no relative who can take on this role.

We noted in all the care records we reviewed there was no care plan which detailed people's preferences and wishes for the end of their lives. It is important to gather this information from people whilst they have the ability to share it, to ensure their end of life experience incorporates their wishes and beliefs.

We looked at what information recorded in people's care records in relation to any spiritual or cultural needs they had. We found some references to people's religious beliefs however we noted in three cases this information had not been recorded.

Is the service responsive?

Our findings

People told us, "I like living here, staff ask what I want on the television or radio" and "I get my paper delivered every day, I like reading and doing crosswords."

We reviewed the care records of six people. We found that care plans were in a state of transition from the old registered provider's format to the new registered provider's format. Some care plans were a mixture of both formats. We found that where new care plans had been created not all available information from existing care records had been included. For example we found there was a care plan supplied by the local authority for one person which included key information including people who had power of attorney and what power they had and that the person was partially sighted. This key information was not transferred to the new plan.

We saw in one care plan there was a detailed life history which had been supplied by a family member, however in other care plans this was not the case and there was very basic information about the person.

We found there was conflicting and inconsistent information contained in care plans. For instance a senior member of staff described to us the needs of a person who lived at the home, we found their care plans did not reflect their current needs in relation to their mobility and the level of support they required.

We found that information which was contained in care records had not been identified and used to ensure people's needs were met. For instance we found in one care record there was clear evidence that some behaviours exhibited by a person could be avoided if specific measures were in place, the information was contained within the daily records showing what methods were required, however this had not been incorporated into the positive behaviour care plan. This meant that staff would not be aware of the best way to distract the person should they become agitated.

We found there were sections of care plans which were not completed, in most cases these had only the name of the person and their date of birth completed. These included end of life care plans, best interest decision records, baseline observations, beliefs and social needs care plans. We did not find any evidence which showed that people had been involved in the creation of their care plans.

We saw there was a form 'my review meeting' which was intended to be completed when a care plan was reviewed with the person and their relative if applicable. We saw in one instance a member of staff had stated there were current issues with a person exhibiting certain behaviours that may challenge and they needed to contact relatives and other health professionals, the rest of the form was incomplete and there was no evidence this meeting had taken place. We did see there was some evidence of care plans being reviewed however there were not detailed records to show who had been involved in these reviews.

We found there was a comprehensive programme of activities planned and being carried out. People we spoke with told us they felt there was a good range of activities and they enjoyed those they participated in. We saw there was an entertainer in the home on the second day of the inspection and people were keen to

join in singing along. There were various other activities taking place including arts and crafts, reminiscence and people watching films and television programmes.

We saw and heard staff offering people choices throughout the inspection. People told us they chose their own clothes, people were offered choices of food and drinks, people could choose what activities they took part in and staff always consulted people before making any changes, for example putting on the television or some music to make sure this was what they wanted.

We saw there was a process for the recording, investigation and response to complaints which were received. People and their relatives knew how to complain and told us they would be confident to do so. We saw there were records of complaints which had been investigated and responded to in line with the policy which was in place.

Is the service well-led?

Our findings

There was no registered manager in post at the time of the inspection. There was a manager appointed however they were absent from the service. There were two peripatetic managers who were responsible for the day to day running of the service. There was also a head of care that was responsible for overseeing the quality and safety of the home.

The manager who was absent from the service had been in post since April 2016. There had been concerns about the quality and safety of the service received which had led to us carrying out this inspection.

Staff we spoke with told us they had found the change of manager's difficult over the past year and they reported they had felt unsettled as a result of this. However staff told us they felt that since the peripatetic managers had been at the home things were 'settling down'.

Staff told us the peripatetic managers were approachable and were visible in the home. Staff felt better supported and able to approach the managers when they needed to and were confident action would be taken in a timely manner.

People who used the service gave mixed feedback in terms of knowing who the manager of the home was; some people were clear whilst others told us they had 'no idea' who was in charge. One person told us "I don't know who the manager is; they come a few times a week."

Staff felt that morale was good and they worked as a team to meet people's needs. There was a relaxed feel to the home during our visits and we found communication to be open and transparent from staff of all levels we spoke with.

We noted on the second day of the inspection there were some confidential care files which were left out in communal areas of the home. We also found the storage of care records was in unlocked cabinets in areas of the home which were not staffed (for example the landing on the first floor), this meant that confidential information was not securely stored and there was the risk that people who were not authorised to access this information could do so.

There had been a delay in the integration of the home into the new registered provider's policies, procedures and processes, which had led to some confusion from staff as to what paperwork should be in place and completed. There were processes we reviewed which were still a mixture of old and new paperwork, which made the information more difficult to access and the results less clear.

We found some of the tools which were in place were not familiar to staff for example the dependency tool which was in place. The peripatetic manager was not able to explain to us the calculations which were included or the meaning of the figures which resulted. This meant that whilst the process was in place it was not effective and did not demonstrate the level of staffing which was required clearly which could lead to errors.

There were audits and monitoring checks in place, however this again was a mixture of old and new processes. There was some analysis carried out for instance on accidents and incidents in the home. Some months there had been a full analysis carried out which showed times of day and areas of the home where there were a higher number of incidents, however other months were either partially analysed or no analysis had been carried out at all. This showed the audits and checks were not carried out consistently and the information was not always analysed to allow managers to accurately measure the quality and safety of the home.

We did find the head of care had identified concerns within the home, and had created an action plan based on their findings. This had been in place prior to our inspection. We found there were other actions plans created after the first day of inspection which evidenced that people with higher level of dependency had been prioritised and work had been carried out to ensure their needs were being met, this had also been carried out for people who were of medium dependency by the second day and work was underway to ensure everyone in the home had accurate up to date care plans in place and all necessary referrals had been made for each person.

There had been a lack of oversight from the registered provider for a period of several months, which had led to the concerns we had received, however this had been recognised and the registered provider had put in place additional resources and plans to ensure these shortfalls were being addressed in a timely manner.

We found the home was meeting the requirements of their registration as they notified us in a timely manner of any incidents which needed to be reported to us.

We looked at the daily care records which were kept for people in the home. We found the records were not sufficiently detailed to allow the reader to gain insight into the way in which the person had spent their day, or how they were on any particular day. We found there was widespread use of generic phrases for instance, 'eyes closed and breathing on checks', which were not specific to the person about whom they were written.

We found the management team were open and transparent throughout the inspection and were aware of the concerns we identified and could show they had also recognised the issues and were taking action to rectify them.

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	<p>Regulation 11 HSCA RA Regulations 2014 Need for consent</p> <p>There was little evidence that mental capacity assessments had been carried out for specific decisions. The service had not ensured that all people who were being deprived of their liberty were being protected by a Deprivation of Liberty Safeguard (DoLS). There was no evidence the home were aware of people who had a Power of Attorney (POA) and what decisions this allowed them to make for the person for which it related to.</p>
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	<p>Regulation 15 HSCA RA Regulations 2014 Premises and equipment</p> <p>The registered provider had failed to carry out work which had been identified as high risk during a fire safety risk assessment of the building to ensure the building would be as safe as possible in the event of a fire.</p>