Delicourt Limited

Oaklands Care Home

Inspection report

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Date of inspection visit:
06 September 2016
07 September 2016

Date of publication:
27 September 2016

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Oaklands is a residential care home that supports up to 45 older people who may be living with dementia or other mental health conditions. When we visited 41 people were living there. The home had a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service and has the legal responsibility for meeting the requirements of the law; as does the provider.

People were at risk because the provider did not have effective arrangements in place to keep the environment clean.

People were at risk of social isolation because the provider did not have suitable activities available for people to participate in at different times of the day

Arrangements for supporting people to take their medicines were not always safe.

The provider did not consistently respond to maintenance requests.

The culture of the home appeared to be task focused and often lacked a person centred approach.

Interactions between staff and people using the service were mixed.

Staff were appropriately trained and skilled to deliver safe care. They all received a thorough induction before they started work and fully understood their responsibilities to report any concerns of possible abuse.

Information regarding diagnosed conditions was documented in people's care plans and risks to health and wellbeing were discussed daily during staff meetings. Staff consistently told us they communicated risks associated with people during hand over meetings and through reviewing people's care.

Referrals to health care professionals were made quickly when people became unwell. Each health care professional told us the staff were responsive to people's changing health needs.

Care plans were reviewed regularly with input from healthcare professionals and relatives.

The registered manager assessed and monitored the quality of care provided by involving people, relatives and professionals. Each person and every relative told us they were regularly asked for feedback and were encouraged to voice their opinions about the quality of care provided.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. These safeguards protect the rights of people using services by ensuring that if there are any restrictions to their freedom and liberty, these have been authorised by the local authority as

being required to protect the person from harm. We observed people's freedoms were not unlawfully restricted and staff were knowledgeable about when a DoLS application should be made.

During the inspection visit the provider responded positively and took action quickly when we shared our concerns.

We found five breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

You can see what action we told the provider to take at the back of this 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?

Requires Improvement

The service was not always safe.

The provider did not have appropriate arrangements in place to ensure the environment was consistently clean.

Arrangements for supporting people with their medicine were not safe.

The provider did not have suitable numbers of appropriately skilled and experienced staff deployed at all times.

Is the service effective?

Good

The service was effective.

The provider followed the requirements of the Mental Capacity Act 2005.

People were supported and encouraged to eat and drink sufficient amounts.

Staff received effective induction and were provided with on-going learning and development.

Is the service caring?

Requires Improvement

The service was not always caring.

Staff did not always display a caring nature towards people.

People's records contained useful information about their past, hobbies and their interests.

Staff respected people's dignity

Is the service responsive?

Requires Improvement

The service was not always responsive.

People were at risk of social isolation due to a lack of activities

available to them.

Care records were persons centred and reflected people's needs. They were frequently reviewed and updated with involvement of relatives and healthcare professionals.

People and relatives told us any complaints about quality of care were acted upon in a timely manner.

Is the service well-led?

Requires Improvement

The service was not always well led.

The provider did not have effective arrangements in place to respond to maintenance requests.

Staff, relatives and healthcare professionals found the registered manager to be approachable and said they had confidence in their ability to improve the service.

The provider regularly sought the views of people living at the home, their relatives and staff to improve the service.

Oaklands 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 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 6 and 7 September 2016 and was unannounced.

One inspector carried out the inspection.

Before our inspection we reviewed previous inspection reports and notifications we had received. A notification is information about important events which the provider is required to tell us about by law.

During the inspection we spoke with the registered manager, the director, 12 members of staff, four healthcare professionals, six relatives and three people.

We pathway tracked six people using the service. This is when we follow a person's experience through the service and get their views on the care they received. This allows us to capture information about a sample of people receiving care or treatment. We looked at staff duty rosters, four staff recruitment files, feedback questionnaires from relatives, personal evacuation plans, policies and procedures and reviewed the provider's quality assurance audits.

We last inspected the home on 30 October 2013 where no concerns were identified.

Requires Improvement

Is the service safe?

Our findings

Relatives, healthcare professionals and our observations found Oaklands to be understaffed, unclean and medicines not consistently being administered appropriately. One relative said: "In the bedroom it doesn't usually smell but it does in other areas". A healthcare professionals said: "The home could do with more staff to make sure the existing ones have enough time to spend with people. They do seem to always be rushed especially in the morning and at lunch".

People did not always receive their medicine at the times they needed it. For example, a medication record dated 20 June 2016 found 0.25 ml of risperidone was administered to someone when it was not required. Another medication error occurred on 11 May 2016 where someone didn't receive their pain relieving patch. Records showed the same person was not provided with their pain relieving medication on the 8 March 2016 when they needed it. An incident document dated 4 May 2016 found medication had gone missing. During the inspection we found medication left on one of the lounge area floors with tissue by its side. We called the registered manager to show her the tablet which was removed straight away. Although we were satisfied the registered manager had carried out robust investigations into missed medicines, we could not be assured people always received their medicines at the times they required it.

This is a breach of Regulation 12 2(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safe care and treatment.

People were at risk because the provider did not ensure the home was consistently clean and free from unpleasant odours. For example, one person's bedroom smelt strongly of urine after it had been cleaned. A member of staff told us it was often difficult to remove the smell of urine because the building was warm with little ventilation. We regularly found crumbs from biscuits and used tissues on the floors in various areas of the home. Feedback from staff taken in July 2016 included: "Open the windows", "Air con" and "Better cleaning material needed". Furniture such as chairs in the home also smelt strongly of urine. A member of staff said: "It's the carpets that smell, it's not easy to keep them clean" and "We are all just used to the smell I don't think we even really notice it anymore". Whilst observing the lunch time meal a member of staff said: "This is driving me mad, all these cobwebs". Questionnaires completed by relatives consistently reported dissatisfaction about the homes aroma. Feedback from one relative included: "Could smell better" and rated "The odours/aromas within the home" as "Very poor".

This is a breach of Regulation 15 1(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safe care and treatment.

We raised these concerns with the director and the registered manager who acknowledged improvement was needed. One the second day of our visit the registered manager had organised a cleaning company to attend the home to discuss the best cleaning materials to be used in order to keep the home clean.

The provider did not have a sufficient number of suitably skilled, qualified and experienced staff deployed at all times.

During the inspection the provider had one head chef, a kitchen assistant, a laundry worker, a bed maker and three domestic staff. From 7am to 2pm there were two senior care workers and 4 care workers, from 2pm to 4pm there were five care staff in total and then at 4pm to 6.30pm the number of care staff went back up to six in total. The Registered Manager and another member of the management team was also on duty between the hours of 7.30am to 4.30pm. During our visit we frequently observed various people receiving support from two members of staff with the use of a hoist. At these periods this meant only four care staff were available to support up to 40 other people in the home. The number of deployed staff stayed the same for the second day of our inspection.

The culture and care provided was task focused and was not centred on people's individual needs. Staff told us they did not have time to engage with people in a meaningful way. For example, a member of staff said: "I can't sit with (person) because I am too busy getting people sorted for lunch" and "We get everyone up in the morning before 10am because otherwise they will miss breakfast or they won't be ready for lunch". The registered manager told us activities were not in place before 2pm because staff were busy caring for people. One person told us they were left for over an hour after having breakfast before being taken back to their room. Staff told us the scenario of people waiting on staff for long periods of time was not unusual.

This is a breach of Regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Staffing.

The service had rigorous processes for reporting any incidents of actual or potential abuse. Staff were fully aware of their responsibilities for recognising and reporting abuse, and for reporting any poor practice by colleagues. We were given examples of issues appropriately raised by staff and were told senior staff were very supportive. We saw from our records that the service notified the Commission of all safeguarding incidents and other agencies, such as the local authority safeguarding team in a timely manner. The provider had an up to date safeguarding policy. This detailed what staff should do if they suspected abuse. We asked staff about whistleblowing. Whistleblowing is a term used when staff alert the service or outside agencies when they are concerned about other staff's care practice. All staff said they would feel confident raising any concerns with the manager. They also said they would feel comfortable raising concerns with outside agencies such as CQC if they felt their concerns had been ignored.

The registered manager told us how risks to people's safety and well-being were managed. They were able to tell us how they put plans in place when a risk was identified. For example, they described the action they had taken to minimise the risk of falling for one person who had a number of falls. There was a plan in place which staff were aware of and used. Where people's needs changed, staff had updated risk assessments and changed how they supported them to make sure they were protected from harm. For example, where people were identified as at risk of developing pressure ulcers, specialist equipment such as pressure relieving mattress had been obtained reducing the risk of them developing skin break down. Safety checks had been carried out at regular intervals on all equipment and installations. Fire safety systems were in place and each person had a personal emergency evacuation plan (PEEP) to ensure staff and others knew how to evacuate them safely and quickly in the event of a fire. The provider ensured the premises and equipment were maintained.

Safe recruitment processes were in place. Staff files contained all of the information required under Schedule 3 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Application forms had been completed and recorded the applicant's employment history, the names of two employment referees and any relevant training. There was also a statement that confirmed the person did not have any criminal convictions that might make them unsuitable for the post. We saw a Disclosure and Barring Service (DBS) check had been obtained before people commenced work at the home. The Disclosure and Barring

Service carry out checks on individuals who intend to work with children and adults, to help employers make safer recruitment decisions.

Good

Is the service effective?

Our findings

Relatives and people consistently told us the food they received was of a good standard. One person said: "The food is just wonderful; I never have any complaints about it". Another relative said: "Since coming here (Person) has put on three stone, they really take care of her weight because she was dangerously thin at the last care home".

People who were at risk of dehydration or malnutrition had been identified and were encouraged and supported to eat and drink sufficient amounts. We observed some people drinking squash, tea and coffee whilst others were frequently offered various drinks. One relative said: "I always see people having drinks and good food". One person said: "I do love the food". Staff accurately described people's dietary requirements. They had good knowledge of people's nutritional needs and were able to tell us the different types of diet people had. A care worker said: "We know about people's food allergies and choices because it's written down and followed". Each of the dietary care plans we looked at accurately reflected what staff told us. These plans outlined the likes, dislikes and preferences of each person and the staff were aware of each individual's preference. We observed people received the correct consistency of food to meet their assessed needs.

People were referred to healthcare services quickly when needed. Records showed staff regularly made contact with the psychiatrists, community psychiatric nurses, the speech and language team and GP practices to discuss specific behaviours and health needs. Documents showed people were supported to receive regular visits from the GP. At the time of our inspection a healthcare professional visited Oaklands to review seven people's care.

Some people who are living with dementia are unable to express their views effectively and may need support to make decisions. 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 care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. Where people did not have the capacity to consent to care a mental capacity assessment had been carried out with the support of relatives and healthcare professionals. DoLS are put in place to protect people's liberty where the service may need to restrict people's movement both in and outside of the home. The manager told us out of the 41 people living at Oaklands 10 people were subject to DoLS and 19 people had been referred to the local authority for assessment. Staff were knowledgeable about the requirements of the MCA and decisions made in people's best interest were consistently and appropriately assessed.

Staff received appropriate induction and were monitored by more experienced staff before they worked

unsupervised. The registered manager provided documentation which showed new staff were in the process of completing their induction programme and were subject to observational competency checks. A member of staff said: "The manager does come round sometimes and watches how we work. We get feedback about how we are doing and we talk about it" Records showed staff were kept up to date with all areas of required training, and had regular 'refresher' training. Staff told us their training was relevant to their role.

Requires Improvement

Is the service caring?

Our findings

Feedback from relatives and healthcare professionals was positive about the care people received. One relative said: "The staff are an absolute lifeline, they are kind, they are polite and always asking me how I am and the kids". A healthcare professional said: "Staff clearly care about people I just think they don't have the time to do more".

We did not always find staff to be caring. Interactions between staff and people were mixed and despite having received training in how to care for people living with dementia, staff did not consistently demonstrate a caring nature. For example, during lunch we observed one person combing their hair with a fork whilst they were sat at the dining table. We observed the person doing this for a period of four minutes. During this time we saw three different member of staff speak with the person whilst cleaning up a drink that had accidently been spilt on the table. At no point did the staff offer to provide an alternative fork or ask the person if they wanted a hairbrush. On another occasion when speaking with one person about the number of staff available in Oaklands a member of staff appeared and joined in with the conversation. The person raised their concerns in front of us to the staff member who was dismissive, walked away and said: "Oh don't worry about it I am sure we will do better next time". The person looked at us and said: "You see what I mean? That doesn't really look like she cares does it?"

During lunch we observed some very caring and compassionate interactions between one member of staff and a person when assisting them to eat. The member of staff was patient, stroked the person's hair, smiled and occasionally stroked the person's face. The staff member's body position, tone of voice and their facial expressions showed compassion and sensitivity towards the person's needs.

Care plans contained guidance that maintained people's privacy and dignity whilst staff supported them with their personal care. This included explaining to people what they were doing before they carried out each personal care task. Records contained information about what was important to each person living at the home. People's likes, dislikes and preferences had been recorded. There was a section on people's life history which detailed previous employment, religious beliefs and important events. Staff explained information was used to support them to have a better understanding of the people they were supporting and to engage people in conversation. Staff were able to demonstrate knowledge of people they cared for. People's preferences on how they wished to receive their daily care and support were recorded. One member of staff said: "There are some new staff here and we are learning about people so we don't know everything but I feel I know enough about most people to be able to help them".

Staff knocked on people's doors before entering rooms and staff took the time to talk with people. People's bedrooms were personalised and contained pictures, ornaments and the things each person wanted in their bedroom. People told us they could spend time in their room if they did not want to join other people in the communal areas. One member of staff said: "We always knock on people's doors before entering otherwise its rude". Staff ensured people's dignity and privacy was maintained during personal care. One staff member explained that if someone was receiving personal care in their room, the door would be closed and they would speak with the person when they provided the care to tell them what they planned on doing. Another

member of staff told us they tried to treat people as they themselves would like to be treated. They said: "It's really important we look after people the way someone we love should be looked after". Documentation showed staff had undertaken training to learn about dignity and respect.

Requires Improvement

Is the service responsive?

Our findings

Relatives and staff consistently told us there were limited activities available for people. One member of staff said: "I am here a lot and it's always dull, it's sad really, I wouldn't want my mum here" A relative said: "They sometimes have something going on in the afternoon but they need to do more for them in the morning and in the evenings".

People were at risk of social isolation due to a lack of activities and appropriate engagement from staff. An events programme located near the front door listed 15 activities scheduled to take place between 1 September and 31 September. The listed activities included art therapy, musical therapy, sharing our past and singing. A member of staff said: "There is nothing to do for people here apart from watching the TV". Another member of staff said: "We get people up, get them dressed and then they are put in the lounge. They just sit there with the TV on but nobody is really interested in that". We frequently observed two people rocking back and forward in their chairs whilst another person continually rubbed their hands on their knees. Self-stimulation can be a sign of neglect. From 12:20 to 12:30 we observed 22 occasions where a staff member walked passed someone who was sitting in a chair in the lounge area. During this time the person was rubbing their eyes with their tissue, wiping tears from their face and eating the tissue. Staff failed to recognise the risks associated with eating inedible objects and did not provide any form of activity or stimulation for the person. Throughout our inspection visit we did not observe anyone engaged in any meaningful activities. One person said: "Some people read the paper and on occasions we have music but it's pretty dull".

This is a breach of Regulation 9 (b)(c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Person-centred care.

We brought this to the attention of the registered manager who told us it was unacceptable. During feedback at the end of our visit the director assured us action would be taken to promote additional activities at various times of the day and said additional staffing would be provided to help the current staff team. We received an email from the registered manager telling us the provider had employed an activities coordinator.

Care plans were person centred and contained guidance about people's personal preferences for how they liked to be supported. For example, one care plan explained how the person liked to be assisted in the community. Another care plan explained how to support a person who needed to be prompted with personal care. Care plans were detailed and explained the actions that were needed to meet people's needs. Bedrooms reflected people's personality, preference and taste. For example, some rooms contained articles of furniture from their own home and people were able to choose furnishings and bedding. People's care plans included risk assessments with clear recommendations to staff about how to reduce the risk that was identified. For example, people who were at risk of falling were provided with walking aids to assist them to mobilise safely.

The provider kept a complaints and compliments record. People and relatives told us they knew how and

who to raise a concern or complaint with. People and relatives told us that if they were unhappy they would not hesitate in speaking with the manager or staff. They told us they were listened to and that they felt confident in raising any concerns with the staff. Complaints had been appropriately investigated and by the registered manager. Relatives and staff were familiar with the provider's complaints procedure and they all said they would speak to the registered manager directly. One relative said: "I have complained before and it has been dealt with".

Requires Improvement

Is the service well-led?

Our findings

Staff, relatives and healthcare professionals all found the registered manager to be approachable and supportive. One relative said: "Anytime I have needed something and wanted something sorted out it has been dealt with". A healthcare professional said: "The manager knows what she is doing". A member of staff said: "We can get help whenever we need it".

Despite having quality assurance processes in place to monitor the quality of care people received, the provider did not always identify and respond effectively to all maintenance concerns. The registered manager told us maintenance checks were conducted on a weekly basis and said plumbing in the home was an on-going problem which was under constant review. People, relatives and staff consistently told us maintenance requests were often not taken seriously. A member of staff said: "Can you see the buckets under the sinks? They are there because we fill them up with hot water from other parts of the home and bring them to people's bedrooms". Another member of staff said: "The hot water problem has been an issue for ages, probably years". During the inspection we checked five people's en-suite taps, a communal shower and a bathroom to see if hot water was available. One en-suite hot tap provided only cold water whilst the communal shower provided very little water when turned on. We asked a member of staff to feel the water from one hot tap and they said: "It's freezing cold". The director told us hot water was an issue and said they frequently had plumbers visiting the home in effort to rectify any issues. The providers quality assurance audits did highlights concerns relating to maintenance but actions were not always followed up or addressed in reasonable time.

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

As part of the registered manager's drive to continuously improve standards they regularly conducted audits to identify areas of improvement. These included checking the management of medicines, risk assessments, care plans, DoLS and mental capacity assessments. They evaluated these audits and created action plans for improvement, when improvements were required. One audit showed a small number of care plans had not been reviewed. A care worker said: "We are all responsible for updating care plans, they are all on the computer and it is clear to see when someone needs a review because everything is on here". The registered manager was knowledgeable about people who lived at Oaklands. They were able to tell us in detail about one person's care needs and showed us computerised records which documented visits from the district nurse and other healthcare professionals". A healthcare professional said: "The manager seems to know people well and appears to be very organised with her paperwork".

Staff told us they felt able to raise concerns. The service had a whistle-blowing policy which provided details of external organisations where staff could raise concerns if they felt unable to raise them internally. Staff were aware of different organisations they could contact to raise concerns. For example, care staff told us they could approach the local authority or the Care Quality Commission if they felt it necessary.

Team meeting records showed staff had opportunities to discuss any concerns and be involved in

contributing to the development of the service. One member of staff said: "We have good managers, they are always helpful and they help us when needed." A member of staff told us there were regular team meetings and said all staff had the opportunity to provide feedback when they completed a staff survey. We saw a poster located on the office door which advertised the next team meeting which was due to take place on the 9 September 2016. The Director and the registered manager told us it was their intention to talk about introducing lead roles for specific subjects such as safeguarding and dignity.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care People were at risk of social isolation due to a lack of activities on offer to them.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider failed to ensure people's medicines were managed safely.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The provider failed to ensure the homes environment was clean and free from offensive odours.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to respond in reasonable time in respect of maintenance requests.

Regulated activity	Regulation
Accommodation for persons who require nursing or	Regulation 18 HSCA RA Regulations 2014 Staffing

personal care	The provider did not have sufficient numbers of suitably skilled, experienced and qualified staff deployed at all times.