

Oakdene Sleaford Limited

Oakdene 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?

Requires Improvement ●

Is the service responsive?

Good ●

Is the service well-led?

Requires Improvement ●

Summary of findings

Overall summary

The inspection took place on 14 April 2016 and was unannounced.

Oakdene Care home is registered to provide personal and nursing care for 35 people who are over the age of 65. It is situated in a grade 2 listed building in the centre of Sleaford. There were 34 people living at the home on the day we visited.

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

The Care Quality Commission is required by law to monitor how a provider applies the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) and to report on what we find. DoLS were in place to protect people where they do not have capacity to make decisions and where it is considered necessary to restrict their freedom in some way. This is usually to protect themselves. The registered manager had made appropriate requests for people to be assessed under the DoLS and all the care provided minimised the restriction on people. Where people were unable to make decisions for themselves processes were in place to ensure decisions were made in the person's best interest.

Systems were in place to identify the number of staff needed to support people and to ensure that staff employed has the appropriate qualifications and skills to meet people's needs. However, staffing levels at night did not support people to receive care in a timely manner. Staff were supported to maintain and improve their skills through ongoing training and support from the nurses and the registered manager. Checks were completed before staff started to work in the home to ensure that they were of good character and safe to work with the people living at the home.

Risks to people while receiving care had been identified and care was planned to keep people safe and healthy and where needed equipment was in place and used safely. Risks around people being able to eat safely and maintain a healthy weight were assessed and advice from healthcare professionals sought when appropriate. However, there was a lack in the variety of food offered to people. In addition information related to fluid intake was not immediately acted upon following a person's discharge from hospital. Medicines were safely managed by staff and available to people when needed.

Staff were kind and courteous when speaking to people. However, we saw at times that staff were focused on the task instead of delivering person centred care and did not always take account of people's feelings or need. In addition the care provided was not always delivered in a timely fashion.

Care plans had been developed with people's involvement and accurately reflected their individual needs. They recorded the care needed to help people to retain and improve their skills in caring for themselves.

However, call bells were cancelled by staff and people experienced delays in staff returning to provide the care they rang to receive. People were engaged by a well developed activities programme which supported them to be entertained with crafts, events and visits out. People who were cared for in their room were also supported to access a variety of entertainments.

The provider has systems in place to monitor the quality of care they provided to people living in the home and took appropriate action when they identified areas of concern. People were able to offer their views on the care they received through meetings and surveys and the provider listened to their concerns and worked to resolve them.

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 consistently safe.

There were systems in place to identify the staffing levels needed to meet people's needs. However, there was not always enough staff to meet people's needs in a timely manner at night.

Appropriate checks were completed to check people's character and to ensure they were safe to work with people living at the home.

Risks to people were identified and appropriate care and equipment was in place to keep people safe. Staff knew how to raise concern to keep people safe from harm.

Medicines were safely managed and available to people whenever needed.

Is the service effective?

Requires Improvement ●

The service was not consistently effective.

There was a lack of variety of food offered to people and meals were not personalised to individual tastes. Changes in people's needs were not effectively circulated to staff. People's abilities to eat safely and maintain a healthy weight were monitored.

The registered manager was aware of and correctly applied the Mental Capacity Act and protected people's rights.

Staff received appropriate training and support to ensure they provided care which met people's needs.

People were supported to access advice guidance and treatment from healthcare professionals.

Is the service caring?

Requires Improvement ●

The service was not consistently caring.

Staff were at times focused on completing tasks and did not always consider the impact this had on people living at the

home.

At times staff cancelled call bells and did not promptly return to provide care for people.

People were involved in the care they received and were supported to maintain and improve their independence.

Is the service responsive?

Good ●

The service was responsive.

Care plans reflected people's needs and staff were aware of what was recorded in each person's care plan.

People were engaged and entertained by a comprehensive activities programme.

People knew how to complain. No formal complaints had been received.

Is the service well-led?

Requires Improvement ●

The service was not consistently well led.

There were systems in place to monitor the quality of care received and to take action if any concerns were identified. However these systems were not fully effective as they failed to identify concerns we found during the inspection.

People were able to give their views on the care they received.

The provider and registered manager was approachable and listened to concerns raised by people living at the home, relatives and staff.

Oakdene 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 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 14 April 2016 and was unannounced. The inspection team consisted of an inspector and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care home.

Before the inspection we reviewed the information we held about the home. This included any incidents the provider was required to tell us about by law and concerns that had been raised with us by the public or health professionals who visited the home. We also reviewed information sent to us by the local authority who commission care for some people living at the home. Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the home, what the service does well and improvements they plan to make.

During the inspection we gathered the views of seven people living at the home and five relatives, as well as two nurses and a healthcare assistant who worked for the NHS. We also spoke with the provider, the registered manager, the nurse, a care worker and the laundry person.

We looked at four care plans and other records which recorded the care people received. In addition we examined records relating to how the service was run including visit times, staffing, training and quality assurance.

Is the service safe?

Our findings

We found the registered manager had completed a staffing tool to help them identify the numbers of staff needed to provide safe care for people. Records showed that the home was staffed in accordance with the tool. The registered manager explained that they did not like to have more than 16 people at the home who needed nursing care as it put the nurses working at the home under pressure. Staffing levels had been increased in October 2015 to meet people's needs at busy times.

However, some of the people told us that at night there were not always enough staff to provide care in a timely manner. One person told us, "There is not enough staff at night. I helped another person a couple of nights ago because she had been left on the toilet and was shouting for help." Another person told us, "I think the call bells responses are shocking... I rang the bell a couple of nights ago in the middle of the night and after half an hour no one had come so I rang the bell again and eventually someone came."

The provider had systems in place to ensure they checked if people had the appropriate skills and qualifications to care for people before offering them employment at the home. For example, we saw people had completed application forms and the registered manager had completed structured interviews. The required checks had been completed to ensure that staff were of good character and safe to work with people who lived at the home.

Staff had received training in how to recognise risks to people's safety and were clear on the action needed to keep people safe. Staff knew how to raise concerns both within the company and with the local authority. They were happy to raise concerns with either the nurse or the registered manager and were aware that the safeguarding number was on the wall for them, visitors and people living at the home to access.

Relatives said they felt their loved ones were safe at Oakdene. Access to the home was restricted by a coded lock and visitors had to be let in by a member of staff.

Risks had been identified and care was planned to reduce the risk of people experiencing harm. For example, risk assessments had been completed around people's likelihood of developing pressure ulcers. Appropriate care was planned to help people stay well. For example, one person's care recorded that they went to bed after lunch to help reduce the pressure on certain areas of the body. Equipment was also in place to reduce the risk of injury. For example, some people had special mattresses on their beds to protect their skin. Charts were in place to monitor that care had been provided in line with people's needs. We saw that they had been completed and showed safe care had been provided.

Where people needed to use equipment to stay safe, there was clear recording in their care plans around what should be used and when. For example, we saw where people needed to use a hoist their care plan recorded the size of sling they needed. We saw that staff followed their training to support people to move safely.

Medicines were well managed and available to people when needed. The nurse completed the medicine

round. The care plans and medicine administration charts in place supported them to administer the medicines safely. In addition we saw that they discussed the medicine with each person so that they knew what they were taking and why. Where people had the ability to manage their own medicines they were supported to self-administer. This was important for people who were at the home for respite and planning on returning to their own home as it allowed them to maintain their skills in this area.

Where people needed their medicine at a specific time, it was offered to them at that time. This meant people received the full benefit of their medicines. Where people had medicine by means of patches on their skin, there was clear recording of when the patches needed changing, when new patches were applied and where and confirmation that the previous patch had been removed. The nurse was aware of people's abilities to take their medicines, we saw one person struggled to swallow their medicine so the nurse ensured that they gave the person their tablets one at a time and ensure that they had been successfully swallowed.

Staff told us and records showed that they had received training in minimising the risk of infection. Staff were able to describe how they worked to reduce the risk of infection. For example, they would use protective equipment such as aprons and gloves and wash their hands and change equipment when providing care for different people. They were also aware of the processes to follow if people had an infectious condition. Visiting health professionals told us that they were happy with the infection control processes in place.

The registered manager had completed infection control audits in November 2015 and April 2016. We saw that these audits were the ones identified by the local authority as the most appropriate ones to use in a nursing home. The registered manager had identified areas for improvements and developed an action plan which clearly recorded what needed doing and when the action would be completed.

Is the service effective?

Our findings

People told us the food was passable, but could be improved. People who chose to follow a vegetarian diet told us that the choice of food offered to them was repetitive. People told us they were offered a choice of food at mealtimes. Staff told us that if they did not like either choice they could ask for anything else they wanted. However, we did not see anywhere where the choice of meal was displayed to help people make a choice and to support them to remember what they had been offered. No one in the dining room at lunch time could remember what they had requested.

Meals were served from the trolley which had been brought into the dining room from the kitchen. However, we did not see any personalisation of the meal. For example, the same vegetables were put on everybody's plate without checking if the person wanted them. One person told us, "Today they called the meal a 'Roast' well you have to laugh really, because it wasn't a roast at all. It was sausage. We usually get asked in the morning if we want the main meal choice, or a salad. The meals could be better. The menu choices are not very good really. It's usually casserole type foods."

Staff were able to explain the signs that would indicate a person was dehydrated and the action they would take which included encouraging the person to drink and raising concerns with the nurse in charge. Where people were at risk of dehydration a record of their fluid intake was kept so that staff could easily identify if they had not drunk enough.

However, staff had not identified all the risks around fluids. One person had been discharged from the hospital the day before our inspection. We saw that their discharge information clearly recorded that they should be on restricted fluids. When we asked staff about their fluid intake they were not aware that it needed to be restricted and had not been monitoring how much the person had been drinking. This meant the person was at risk of becoming ill again and needing a readmission to hospital.

People who were at risk of being unable to maintain a healthy weight had been identified and appropriate support from healthcare professionals had been sought. Nutritional supplements were available for people if advised by the GP. We saw people could choose how they took the supplements. For example, some people chose to have them as a drink, where other people preferred to have them in their food, for example, their porridge.

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 checked whether the home was working within the

principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

The registered manager had understood their responsibilities under the MCA and had applied for DoLS where people were unable to make the decision they wanted to live at the home. There were no conditions on either of the DoLS which had been approved.

We saw that the registered manager had discussed with people any arrangements they had made for other people to make decision on their behalf. Appropriate legal documentation which supported the arrangements were available in people's care plans. We saw where people had not made any arrangements the provider and registered manager worked with the MCA. For example, one person at the home had deteriorated and the home was no longer able to meet their needs. The person was unable to make a decision about their future care. The registered manager was working with the family and health and social care professionals so a decision could be made in the person's best interest.

The provider had an induction programme for all new staff which included time in a classroom and shadowing an experienced member of staff. New staff were on a six month probationary contract to give the registered manager the time to see if they were able to develop the skills needed.

Staff told us that they had received appropriate training to ensure they had the skills to provide safe effective care to people. Staff were also supported by regular training to update their skills in key areas such as fire safety retaining and protecting people from harm. The registered manager monitored the training completed by staff and had systems in place to prompt people when training needed refreshing. Staff were supported to study for recognised qualifications in care. The nurses were given help to provide evidence to their professional body that they were continuing to develop their skills in line with changes in recommended best practice.

Staff told us and records showed that they had regular supervisions and annual appraisals. In addition the registered manager completed observations to check that they were working in line with their training and that the care provided was safe and effective. For example, we saw they completed competency checks on staff who administered medicines.

Individual care plans included all the information needed to support people's day-to-day health needs. Additionally, we saw people had been supported to arrange and attend for eye tests and their prescriptions had been updated where necessary. Records showed other health professionals such as GP's and the community mental health team had been included in people's care when needed. People were also supported to attend screening for preventative healthcare.

Is the service caring?

Our findings

The staff were kind, caring and courteous to people living at the home. Visiting relatives told us that people were treated with dignity and respect. We heard that staff were respectful when speaking to people. For example, staff were heard asking people if they wanted help to cut up their meal or if they could manage themselves. People were also offered aprons to protect their clothes when eating.

However, people living at the home told us that care was not always provided in a timely fashion as staff would often cancel the call bell and then forget to return to provide the care. One person said, "They do come eventually to respond to call bells, but often they just cancel the bell ringing on the board and say, "Wait a minute I`ll be back and then forget about you." Another person told us, "I know if the care staff are busy with others they can't be in two places at once. But the thing with cancelling the call system on the board means they then often forget to come back to us."

Some care was delivered in a task focused way instead of being person centred. For example, people were put on the rota to have a bath once a week. A relative told us, "The staff are always kind, courteous and on the whole are good. They have a bath once a week, [my relative's] is a Tuesday afternoon slot." Staff told us that if people preferred to have a bath more frequently they could only support them if they had time.

At times staff focused on the task they were completing and did not always consider people's needs or feelings. An example of this was a person who was seated far too far away from the dining table and was slipping down in their wheelchair and consequently spilling food down the front of their clothes. We asked staff if the person could be assisted to be more comfortable. The member of staff noticed that the person had their slippers on the wrong feet, but did not change them over for the person. At the end of the meal another member of staff also noted that the person`s slippers were on the wrong feet, but they also did not rectify them.

We also saw that one person was slow at eating their meal and that it took them over an hour to eat their main course. A member of staff came and attempted to take their meal away in order to take them to the communal room along with everyone else who had left the dining room. The person objected saying they had not yet finished, and had not yet had their dessert. Another member of staff came into the dining room and proceeded to remove all the table cloths from the dining tables including the table this person was sat at.

We saw a member of staff was stood over a person while supporting them to eat. Another member of staff suggested that they get a chair and the member of staff supporting the person said, "Thanks I've been stood there breaking my back." This was not respectful to the person they were supporting.

In addition we saw that the provider did not support people to see the GP at a time which was convenient to them. Instead they enabled the GP to see people whenever they arrived at the home. We saw that two people who were eating their midday meal were asked by the provider if they would leave their meal to go and see the GP. One had finished their main course and chose to have their pudding after seeing the GP. The

other person left their main course half eaten. We saw that when they returned to the dining room, staff expected them to continue eating their cold meal. The provider had said they could have a fresh meal and we asked staff to get this for them.

A third person who was waiting to be served their meal was also asked to see the GP. When they returned to the dining room, another person was sitting in the chair they had previously occupied. Staff found them an alternative place to sit, but the person was unhappy as they felt they had been forgotten.

Staff were aware of which people were living with a dementia and that at times they were disorientated and needed orientating to the date and time. We saw all the communal rooms had large clocks, and there was a weather board in the main dining area showing time, date and weather. However, the provider had not ensured that people living with dementia could find their way around the home independently. For example, signs contains words but no pictures.

People had been involved in developing their care plans and knew what was recorded about them. They also knew when records were being kept about how much they were eating and drinking. Where appropriate relatives also knew about the care plans and were involved in reviews and were kept up to date with changes in people's care needs. One person told us, "Yes I do know about my care plan, although I didn't know that's what it's called."

People were involved in their care and supported to maintain and improve their independence. Staff were aware of what care people could provide for themselves and ensured that people had access to equipment to support their independence. For example, one person was given special cutlery so they could remain independent with eating. A relative told us, "I used to stay and feed my wife because I thought it was helping the staff who are always busy, but the GP thought it would be best to encourage her to do it for herself to promote her independence. So I don't come in at mealtimes now and sure enough she is now feeding herself again."

Most people lived in their own room, but five rooms in the home larger and were shared by two people. We saw that each room had a dividing curtain to protect people's privacy while receiving personal care.

Is the service responsive?

Our findings

A relative said, "I don't have any worries about my relative's care here. She is very well cared for." Another relative said, "I am very happy with Oakdene, they are extremely kind and caring towards my relative."

Care plans recorded the information needed to provide safe, effective person centred care for people. An example of this was the information recorded about people's pain levels and painful areas that needed extra care when supporting people to move. Staff told us they had time to read care plans and to understand people's care needs. They were able to display this to us when describing the care they provided for people as it matched the care recorded in each person's care plan. In addition there was a handover meeting at the end of each shift. Staff told us they were made aware of any changes in people's needs at handover.

Some of the people living at the home were there on a temporary basis until they were well enough to return home. Staff were aware of their needs and how to support them. For example, one person was struggling to feed themselves, staff monitored but did not intervene as this was a skill they needed to have to return home. NHS healthcare professionals completed the care plans for these people and reviewed them on a weekly basis. They had weekly meetings with the staff at the home to update them on people's needs.

There were good processes in place regarding managing people's wounds with photographs and measurements taken to show how well the wound was healing. We found that one person had been able to reduce their medicines as staff now understood the person's needs better following consultation with the specialist nurse. Pain when changing dressings had been reduced as they were now soaking the dressings before removal.

People who were living with diabetes had their needs identified. Their care plans clearly recorded how often they needed their blood sugar monitoring and what range it should be in. Any advice from specialist nurses was recorded. One person was on enteral feeds and a diabetic. Enteral feeding is when food is delivered to directly to the stomach using a tube. Appropriate advice regarding monitoring and maintaining blood sugar levels were clearly recorded. The nurse was able to explain exactly how the care was provided, what the risks were and what action they should take in an emergency.

People told us that they were supported to be active and entertained by the activities coordinator who worked five days a week. All the people we spoke with were happy with the activities provided during the week, but felt that more was needed at the weekends. One person told us, "The activities person is marvellous but sadly she is not here at weekends and so it is down to one of the relatives who comes in." Another person living at the home said, "I think we could do better here with some entertainment at weekends."

We saw that people were engaged in a variety of activities. There were craft activities taking place in the morning in preparation of the Queen's birthday celebrations. One person had chosen not to engage with the craft activities and a member of staff was sat with them reading the paper. A relative said, "Oh yes, they do things together. A singer comes in regularly and there's always something happening, they have visits out

now and again." People who spent most of their time in their room told us that they had ample opportunities to participate in activities if they so wished and were included in all events if they chose to be. Care plans recorded people's hobbies and interests from before they moved into the home and that people should be encouraged to continue to access external activities such as clubs.

We saw there was a notice telling people how to complain in the main entrance. People told us they were happy to raise complaints with the registered manager or other staff. Relatives we spoke with said they knew who to go to if they had any worries or complaints. They felt the registered manager had a good strong presence and was often seen about the home and they could go to them with any issues. One relative who had raised an issue with the registered manager told us they were confident that the management were positively trying to deal with the matter. There had been no formal complaints received since our last inspection.

Some of the people living at the home told us that they had raised a concern with the registered manager about two people who by mistake went into people's bedrooms during the night-time. They were confident that the registered manager would take action and that they had been taken seriously. Staff told us that if anyone raised a concern with them they would tell the registered manager.

Is the service well-led?

Our findings

The registered manager completed quality checks around the home on a regular basis to identify any areas of the environment or the care which were not up to standard and which may require improvements. We saw where issues were identified the registered manager took action to keep people safe. For example, we saw they completed a falls audit on a monthly basis and looked at who had fallen and at what time of day. This supported them to review the care plans and arrange for reviews and support to be put into place to keep people safe. In addition environmental checks such as infection control audits and cleaning audits were completed.

However, the provider and registered manager had not identified the concerns which people raised with us during the inspection, such as the lack of variety of food and the staff cancelling call bells. Although both spent time around the home they had not identified that at times the staff were task focused and failed to provide a caring service. In addition the monitoring systems had not picked up that staffing levels at night had led to people having long waits to receive care at night which may impact on their ability to maintain their dignity.

Accidents and incidents were recorded and appropriate action had been taken to keep people safe. However, we saw that body maps completed to show where people had bruises or injuries on their bodies were not dated so it was not possible to see when the injury occurred. This meant it was not possible for the registered manager to effectively audit accidents and incidents to see if there was a pattern to when they were occurring.

People told us that the provider and the registered manager were both seen about the home on a regular basis and that both were approachable. People told us they felt able to raise any concerns with the registered manager and that the registered manager would take appropriate action. One person living at the home told us, "If there have been any issues I have addressed them, they have been dealt with and we have moved on which is just how it should be." A relative said, "If I had a concern I would go see the manager and sort it out straight away." However, several people raised concerns with us that the home did not run as well when neither the provider nor the registered manager was about. One person said, "The owner is good but he disappears Thursday afternoon until Monday, so things aren't the same when he is not around. Weekends are very different here without management around." Another person told us, "The boss man is lovely – but he's not here at weekends of course."

People living at the home and their relatives told us that they were supported to raise their views on the care they received and if any improvements were needed through regular residents' and relatives' meeting and quality assurance surveys. One relative told us, ""Yes I know about the relatives' meetings and have attended, and I know they have questionnaires." Records showed that the results of the latest survey completed in December 2015 had been reviewed and areas for improvement identified. For example, relatives had raised concerns about not being kept up to date with people's needs or what was in their care plans. The registered manager was going to review which relatives had the person's consent to be updated about their care needs and to review care plans.

Staff also told us that the provider and the registered manager were approachable and would respond to any concerns raised. One member of staff said, "The manager's door is always open and you can go and speak with her if you have any concerns. She does listen or you can go to the provider." In addition they told us that the registered manager had clear standards that were acceptable and that they ensured everyone was aware of and worked to those standards. Staff told us and records showed that they had regular meetings to discuss any concerns, changes and any new guidance they needed to be aware of.

We found that the registered manager knew all the people living at the home and their relatives and was aware of people's needs. This meant they were able to monitor if care was meeting people's needs appropriately. In addition NHS healthcare professionals who provided care for people living at the home told us that the communication between the community staff and nurses and the registered manager was good and that the registered manager was proactive about raising any concerns that they had.