Care Quality Commission

Oak Cottage Care Limited

Oak Cottage

Inspection report

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Ratings

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

Overall summary

We carried out an unannounced inspection on 5 November 2015. The service had been last inspected in January 2015 in response to concerns about the quality of the service provided. We had looked at whether the service was safe, effective and caring and we found they had not met five regulations. This was because we had concerns about how people's medicines were managed and the environment was not always safe. Also, care had not always been provided in a way that achieved good results for people who used the service. We told the provider to make the required improvements and they told us what action they would take to improve the quality of the service and meet the regulations.

The service provides care and support for up to 21 older people, some of whom may be living

with dementia and chronic health conditions. On the day of our inspection, 18 people were being supported by the service.

Summary of findings

Although the service has a registered manager in post, he has not been responsible for the day to day management of the service for a while. A deputy manager has taken on this role, but has not yet registered with the Care Quality Commission. This is in breach of the registration conditions as the registered manager was no longer managing the regulated activities for which they had been registered and had not formally notified us of the change. You can see what action we have taken against them at the back of the full version of the report. 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.

People were safe and the provider had effective systems in place to safeguard them. Staff had been trained to safeguard people and were able to identify when people required additional support. However, staff did not always take enough steps to protect people from possible risk of acquired infections.

There were personalised risk assessments in place that gave guidance to staff on how risks to people could be minimised. Risks associated with day to day running of the service had also been well managed.

People's medicines were now being managed safely and administered by trained staff in a timely manner. However, the provider did not always order on time the equipment needed for other professionals to provide people's treatment.

The provider now had effective recruitment processes in place so that people were supported by suitable staff. There was sufficient staff to support people safely and they had received supervision, support and effective training that enabled them to support people appropriately. The deputy managers and staff now understood their roles and responsibilities in relation to providing care in accordance with the requirements of the Mental Capacity Act 2005 (MCA) and the related Deprivation of Liberty Safeguards, and appropriate referrals had been made to the relevant local authorities.

People were supported to have sufficient food and drink. Assessments had been completed for people deemed to be at increased risk, but it was not clear how often these were done for everyone else. People were also supported to access other health and social care services when required and the provider had been responsive to the advice given by the local authority so that people received timely treatment when unwell.

People were supported by staff who were caring, kind and friendly. However, some people's privacy was not always respected because staff sometimes used their bedrooms to support other people in private.

People's needs had been assessed and care plans were in place. However these did not always take into account their individual preferences and choices. Activities were provided within the home, but it was not clear how people were supported to pursue their hobbies and interests or meet their religious or spiritual needs.

The provider had a formal process for handling complaints and concerns. They encouraged feedback from people and their relatives so that they had the information they required to improve the quality of the service.

The provider now had processes to assess various aspects of the service. However, they did not have a system that enabled them to bring this information together so that they could analyse it and monitor trends.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was not always safe.

There were effective systems in place to safeguard people, but they were not always protected from a possible risk of acquired infections.

People's medicines were now administered safely by trained and competent staff.

There was enough skilled staff to support people safely.

Requires improvement

Is the service effective?
The service was not always effective.

Staff now received effective training to maintain and develop the skills and knowledge they needed to support people appropriately.

Staff understood people's care needs and provided the individual support they needed. However, required equipment was not always ordered quickly.

People had enough and nutritious food and drink to maintain their health and wellbeing.

Requires improvement

Is the service caring?
The service was caring.

People were supported by staff who were kind and caring.

People were supported in a way that maintained their dignity, but their privacy was not always protected.

People had been given information about the service in a format they could understand.

Good

Is the service responsive?
The service was not always responsive.

People's care plans did not always take into account their preferences and choices.

There was little evidence that the provider involved people in planning and reviewing their care.

The provider had an effective complaints system.

Requires improvement

Is the service well-led?
The service was not always well-led.

The registered manager had not formally notified us that they no longer managed the regulated activities for which they had been registered.

Requires improvement

Summary of findings

People who used the service and their relatives were enabled to routinely share their experiences of the service.

There was no system to enable the provider to bring the information from various audits together so that they could analyse it and monitor trends.

Oak Cottage

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 November 2015 and it was unannounced. It was carried out by two inspectors.

Before the inspection, we reviewed information we held about the service including previous inspection reports, concerns raised by staff or external professionals and notifications they had sent us. A notification is information about important events which the provider is required to send to us.

During the inspection, we spoke with three people who used the service, two visiting relatives, three care staff and the two deputy managers. We met briefly with the registered manager when we arrived at the home and when we were giving feedback at the end of the inspection.

We reviewed the care records and risk assessments for six people who used the service. We looked at the recruitment and supervision records for five care staff, and training for all staff employed by the service. We reviewed information on how they managed medicines and complaints, and how they monitored the quality of the service provided. We saw the report of a review carried out by the local authority in April and May 2015. We observed care in the communal areas of the home.

Following the inspection, we contacted three professionals by telephone to get their feedback about the quality of care provided by the service and we spoke with one of them. Also, we sent emails to two other professionals and we received a response from one of them.

Requires improvement

Is the service safe?

Our findings

During our previous inspection in January 2015, we had found that people's medicines had not always been managed safely and risks posed by some medicine treatments had not been fully assessed. The deputy managers and staff were unable to tell us what the settings should be on the pumps for the air mattresses used to ensure that people mainly cared for in bed did not develop pressure area damage to their skin. The premises had not always been maintained in a way that ensured that people were safe from trip hazards or fire risk. Infection control guidance had not been followed when supporting a person who had been experiencing diarrhoea and vomiting. Also, the provider's recruitment practices were not always safe because they had not obtained appropriate references for all staff they employed.

During this inspection, we found that improvements had been made so that people's medicines were managed safely. People had no concerns with how their medicines were given to them. The provider now had a system in place to carry out regular audits to check that medicines were being stored and administered in accordance with good practice guidance. An audit in May 2015 by the pharmacist who supplied the medicines to the home found that medicines were being managed safely. Their only suggestion was that all opened medicines that were not in blister packs should be dated and we noted that this had been followed. One of the deputy managers had taken a lead role in managing medicines within the home. Following a recent change from blister packs to medicines being administered from their original boxes, they mainly administered medicines until they were confident that the rest of the staff would be able to do so competently and safely. They planned further training and competence assessments for all staff that administered medicines.

We saw that the medicine administration records (MAR) from August 2015 had been completed accurately with no unexplained gaps. Of note, the deputy manager had prepared information about each person's medicines so that staff understood what it was for and the side effects to look out for when supporting people. Although the stocks of most medicines were in accordance with what had been ordered, the deputy manager could not account for why there was a discrepancy in the amount of one controlled medicine. It had been recorded on 4 November 2015 that there were 66 tablets, but only 64 could be accounted for. The deputy manager said that they would clarify this inconsistency with the night staff so that accurate records would always be kept.

Care was now provided in a safe environment because there was evidence of regular testing of electrical and gas appliances, as well as systems to prevent the risk of fire. We noted that fire equipment had been serviced in August and October 2015. The chair lift had been checked in July 2015 and the hoists used to assist people to move had been serviced in June 2015. Also, a record of accidents and incidents was now being kept, with evidence that measures were put in place to prevent them from happening again. For example, bruising noted on a person's arm in July 2015 had been recorded on the 'body map' form and they had been seen by their GP. The provider was also working on a form to review 'falls' so that it would include information on what action was taken following the incident.

People's risk of developing pressure sores had reduced because the provider now had the information needed to understand how air mattresses should be set for each person. A deputy manager told us that the community nurses were responsible for ensuring that these were set correctly and since the inspection in January 2015, they had visited to check a person's mattress. We noted that no one had pressure sores. A community nurse told us that they were concerned that there was still a disregard for infection control and prevention measures. They gave us an example of when they arrived to change someone's catheter and they were taken to someone else's bedroom rather than the person's own. They said that the only reason for this was that the other bedroom was nearer to walk to and the member of staff who took them to the room had not thought about the possible risk of cross infection. However, a deputy manager disputed this. They said that there was confusion about which person they were coming to see and this had been explained to the nurse at the time. We noted that the home was clean and there was an arrangement in place for clinical waste to be collected weekly by an external company.

The provider's recruitment processes had improved because they now had a system to ensure that they obtained appropriate references for all staff employed by the service. Also, they kept records of the other pre-employment checks they had completed including

Requires improvement

Is the service safe?

obtaining Disclosure and Barring Service (DBS) reports for each member of staff. DBS helps employers to make safer recruitment decisions and prevents unsuitable people from being employed.

People and their relatives told us that they were safe living at the home and that staff supported them safely. One person said, "Living here is lovely. It's not home, but it suits me." The relative of another person said, "I knew straightaway when I visited for the first time that [relative] would be safe here." During our time at the home, we observed that people appeared happy and relaxed.

The provider had a safeguarding policy in order to give guidance to staff on how to keep people safe. Information about safeguarding people was displayed on the notice board near the entrance to the home so that people who used the service, staff and visitors had accessible contact details of the local authority safeguarding team if required. Also, staff had been trained on how to safeguard people and they demonstrated good understanding of the procedures they would follow if they suspected that people were at risk of harm.

There were personalised risk assessments for each person which identified risks they could be exposed to and included the steps to be taken to minimise the risks. For the majority of people, these assessments were for risks associated with supporting them to move, falling, pressure area damage to the skin and not eating or drinking enough. Depending on their needs, other people had specific risk assessments in place. For example, a person had been assessed in relation to the use of bedrails to prevent them from falling from their bed. We found people were mainly kept safe because their risk assessments had been reviewed regularly or when their needs changed to ensure that they continued to receive the care that was appropriate for them.

There was enough skilled and trained staff to support people safely, and this view was supported by a relative and the staff we spoke with. The relative said, "I feel that they have enough staff as my [relative] is always well looked after." A member of staff said, "Work is always balanced out between us, there's enough staff." Another member of staff said, "There's always enough staff here and we work well as a team." The duty rotas were planned in advance so that there was always enough staff to support people safely and meet their individual needs. When required, the deputy managers were available to work alongside staff to support people during week days. One of them normally worked longer hours and weekends to also provide support to the staff and leadership.

Requires improvement

Is the service effective?

Our findings

During the inspection in January 2015, we had found that staff did not always monitor whether people were eating and drinking enough. Appropriate referrals to other health professionals had not been done promptly when people were identified as being at risk. The provider did not understand their responsibilities in relation to Mental Capacity Act 2005 (MCA) and the related Deprivation of Liberty Safeguards (DoLS), and they had not applied to the local authority for authorisations for anyone. Staff supervision meetings were not held regularly and training was not always provided in a timely manner.

During this inspection, we found that some improvements had been made. People and their relatives told us that staff knew how to support them and did this well. One person said, "They look after me really well." A relative of one person said, "[Relative] is well looked after."

People had been supported to have a varied and balanced diet. People told us that they enjoyed the food. One person said, "The food and drinks are good. We have loads to eat." A member of staff said, "People have good choices of what to eat and always have enough." Positively, a person's relative told us that their relative had put on weight since they had been at the home. We observed the lunchtime meal and noted that the food appeared well cooked and appetising. People ate their meal in the lounge because the dining room windows were being replaced. They were able to comfortably because they had small tables that could be adjusted to suit the height of their chairs. Most people ate independently and staff provided support if required. A member of staff said, "We encourage people to eat and drink as much as possible. The food is healthy." We noted that people's weight was monitored monthly and those deemed to be at risk had their nutritional screening assessments completed monthly too. However, we found these were not consistently completed monthly in accordance with the provider's form for people assessed as being at low risk of not eating enough and the provider had not made it clear how often they would be reviewed.

There was evidence that the provider was now working closely with health and social care professionals so that people received the care they needed in a timely manner. People were supported to access other health and social care services, such as GPs, dentists, dietitians, opticians, occupational therapists and chiropodists. However, a community nurse told us that they did not always order the equipment needed for people. For example, they told us that they occasionally arrived at the home to change a person's catheter, but new ones had not been ordered. This resulted in delays in people's care while waiting for catheters to be delivered. Also, the secure gate entry system did not always work. They told us of a day they had arrived in the morning and could not get in contact with the home because the phone had not been answered too. It was fortunate that they were able to return in the afternoon otherwise for that day, people would not have had the care and treatment they needed. An incident resulting in a person who was unwell not being sent quickly to hospital, had prompted the local authority that commissioned the service to give guidance on what to do. This was particularly for when a person had vomited and was clearly unwell. We saw that this information had been given to the staff and kept in people's care records that we looked at.

The provider had taken appropriate action to ensure that people's care was provided in accordance with the requirements of the MCA. The 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. We noted that staff understood the relevant requirements of the MCA, particularly in relation to their roles and responsibilities in ensuring that people made informed decisions and they consented to their care and support. Although we saw consent forms in relation to people being supported to take their medicines and sharing of their care information with other professionals, it was not clear whether people consented to being at the home and supported with their personal care. However, a deputy manager showed us that they had devised a new consent form that included this and they were going to discuss it with people at the next residents' meeting. For those without capacity to make decisions about their care, we saw evidence that mental capacity assessments had been completed in conjunction with people's relatives and other professionals, such as social workers so that care was provided in their best interest.

We also saw that when required to safeguard people, the provider had now sent referrals to the local authority so

Requires improvement

Is the service effective?

that assessments could be completed in accordance with DoLS requirements. Some authorisations had been received from the relevant local authorities so that any restrictive care met the legal requirements. However, we noted that the majority remained outstanding due to the high amount of applications local authorities had to deal with.

The provider had now ensured that staff had the training they needed to enable them to gain the right knowledge and skills to support people well. They told us that training was mainly provided by two external organisations, but they were also considering introducing e-learning so that staff could update some of their training a lot quicker. They now had a system to monitor staff training so that they updated their skills and knowledge in a timely manner. Staff were complimentary about the training they received. One member of staff said, "Training is good. I shadowed seniors for a while before I did all my courses." Another member of staff showed that their training had been effective because they could clearly describe how the MCA and DoLS impacted on the care of people who used the service. In preparation for them applying to be a registered manager in the future, one of the deputy managers had started a Level 5 diploma in health and social care leadership and they told us that this was going well.

The provider now ensured that staff had regular supervision and this was evident in the staff records we looked at. Staff also confirmed this and they said these meetings were used positively to evaluate their performance and to identify any areas in which they needed additional support or training. One member of staff said, "We have regular supervision with managers. They are clear about what they expect of us."

Good

Is the service caring?

Our findings

During the inspection in January 2015, we had found that staff had failed to maintain people's dignity and privacy because we had observed personal care being provided to a person with their bedroom door open. We did not observe such incidents during this inspection, but we found that staff did not always respect people's privacy because they sometimes allowed for use of people's bedrooms by others without their permission. We were told an example of this by a community nurse and also, when we wanted to speak to a person in private, we were taken to another person's bedroom. There was clear lack of awareness that this was not promoting people's rights to privacy. Although further training was necessary to ensure that staff paid more attention to these issues, they did not have a detrimental effect on people's quality of life.

People and their relatives were positive about the care they received. They told us that staff were caring towards them. One person said, "The staff are lovely, I get on great with them." A relative of another person said, "The other residents are lovely and the staff are too." Other comments we saw from the survey people completed earlier in the year included, 'Staff are fabulous and very patient'; 'Staff are great with the residents'; 'People are very well looked after'; 'Staff are friendly and always on the ball'.

We observed respectful interactions between staff and people sitting in the communal areas of the home and it was evident that they had good relationships with people and their relatives. There was also a happy, relaxed and friendly atmosphere within the home, and staff checked how people were each time they came into the lounge.

Also at times, staff talked to people they were sitting next to. During lunchtime, a member of staff explained what was in the plate of a blind person. They also made sure that their plate guard was placed properly so that they could eat independently without spilling their food.

People had been enabled to make choices about how they wanted to be supported. They said that staff took account of their individual choices and preferences in order to provide the care they wanted. One person said, "I decorated my own room to my taste." Also, people maintained relationships with their family members and friends because they were able to visit whenever they wanted. A relative we spoke with confirmed this when they said, "I visit about twice a week and I was happy that I did not need to make an appointment before visiting." A person who used the service said, "My relatives can come whenever they like. It's like their home too." A relative also commented in the survey that they felt welcome and 'were always offered tea or coffee' when they visited.

We noted that information had been given to people in a format they could understand to enable them to make informed choices and decisions about their care. When they started using the service, they had been given a 'service user guide' that included a range of information about the service. A copy was also displayed on a notice board by the entrance to the home. Some people were able to understand this information, but other people's relatives or social workers acted as their advocates to ensure that they received the care they needed. Also, people had access to information about independent advocacy services they could contact if required.

Requires improvement

Is the service responsive?

Our findings

People's needs had been assessed and appropriate care plans were in place so that they received the care and support they required. However, we noted that the care plans we looked at did not always reflect that people's preferences and choices had been taken into account in planning their care. Additionally, it was not always evident whether people and their relatives had been involved in this process. One of the people we spoke with told us that they had not been involved in planning their care and that they had not seen their care plan. They said, "I haven't seen my care plan and I don't think I was involved in the planning."

The provider's forms indicated that people's care plans should be reviewed monthly, but this was not consistently done. For example, the care plans for two people had been last reviewed in August 2015. Also, a care plan for a person with advanced dementia did not reflect how staff supported them. This was because the care plan stated that the person was to be reminded of events in their life which they regularly forgot, but a deputy manager told us that following advice from an external professional, they now 'went along' with whatever the person said to avoid distressing them further when corrected. This showed that the care plan had not been amended following the advice and could result in inconsistent approaches when supporting the person.

There was evidence that activities had been planned for people to take part in within the home. There was a timetable on display which showed that various activities were provided including pampering on Mondays; bingo; exercises; art and crafts. People normally relaxed on Fridays or others had outings for shopping. One person said, "We have games and bingo, and we all help each other out with things around the home." We noted that some people spent their day chatting with others in the lounge. Some of the people went out regularly either with care staff or accompanied by staff from a local charity. The service also planned an annual trip to the seaside during the summer months. At times, people also went out with their relatives for recreational activities such as shopping and eating out. However, it was not clear how people's religious or spiritual needs were being met and how they were supported to pursue their hobbies and interests.

The provider had a complaints system in place and information was displayed on a notice board to tell people what to do if they wished to raise a complaint or if they had concerns about any aspect of their care. We also noted that this had been further explained to people during a meeting attended by seven people in July 2015. There had been no recorded complaints since the last inspection in January 2015. The provider had introduced a 'grumbles book' so that they could record minor concerns people might have about the way their care was being managed or if they had suggestions for improvements. People said that they would always talk to the manager if they needed to complain. A relative of one person said, "I have nothing to complain about." They also said that they knew that the manager would sort anything they would have raised concerns about.

Requires improvement

Is the service well-led?

Our findings

The service had a registered manager, but we found that they had not been managing the day to day running of service for a while. They had not given us formal notification of this or made an effort to swiftly register another manager. Evidence from our previous inspections in July 2014 and January 2015 showed that the two deputy managers had been managing the service during those periods. Although we were told that the registered manager gave support and advice to the deputy managers, it was evident that they were no longer managing the service. We found this was in breach of their registration conditions that required them to carry on the regulated activities they had been registered for. This was a breach of Regulation 15 (Registration) Regulations 2009.

During the inspection in July 2014, we had found that the provider did not have effective systems to assess and monitor the quality of the service provided. Also, the two deputy managers did not have defined roles and therefore were not always clear about who did what within the service. They now had distinct roles and they therefore contributed more effectively to the development of the service. Although we saw that significant improvements had been made and the provider now had processes to regularly audit various aspects of the service, they did not have a system that enabled them to bring this information together so that they could analyse it and monitor trends. We found that records in relation to people who used the service had not always been kept up to date because they had not been reviewed as specified by the provider's own forms.

The provider had a whistleblowing policy to enable staff to report concerns within their workplace. We had received five whistleblowing concerns in the months following our inspection in January 2015. A deputy manager told us that they did not know why staff chose to raise concerns with external agencies before giving them an opportunity to look into the issues and make the required improvements. They said that responding to external agencies had taken a lot of their time from the important work they needed to do to improve the quality of the service provided to people. They were now trying to encourage staff to share concerns with them first. They had discussed this in staff meetings and they were also planning to send a questionnaire to each member of staff with that month's payslips to find out why they did not feel able to share their concerns with them.

People, their relatives and staff told us that the deputy managers were approachable, supportive and promoted an 'open culture', where they, their relatives and staff could speak to them at any time. A member of staff said, "The management is great. I can talk to the manager about anything." Staff also told us that they worked well as a team and supported each other really well. We saw that regular staff meetings had been held for them to discuss issues relevant to their roles. Staff said that the discussions during these meetings were essential to ensure that they had up to date information that enabled them to provide care that met people's needs safely and effectively. There were also meetings for managers and senior care staff if they needed to plan specific projects or respond to any concerns. A deputy manager also attended quarterly provider forums arranged by a local care provider association. They found these useful as providers shared some ideas about how to improve services.

There was evidence that the provider encouraged people and their relatives to provide feedback about the service by sending them annual surveys. The results of the survey completed in early 2015 showed that people were mainly happy with the quality of the service provided. Some of the positive comments were about the cleanliness of the home, and that staff were always caring and friendly. A deputy manager told us that they had recently outsourced this and the local provider association would be sending questionnaires on their behalf in the future and analysing the responses. They told us that they had always received similar responses each year and felt that people might be a bit open about their comments if they knew that an independent organisation was doing the survey. We saw that regular meetings were also held with people who used the service. However, these were not always well attended, with evidence that only two people took part in the last meeting in October 2015. A deputy manager told us that they would continue to use these to communicate any changes to how people's care was managed.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 CQC (Registration) Regulations 2009 Notifications – notice of changes **The registered manager had not formally notified us that they no longer managed the regulated activities for which they had been registered.**