Care Quality Commission

Oak Cottage Care Ltd

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?	Requires Improvement

Overall summary

We carried out an unannounced comprehensive inspection on 17 July 2014. After this inspection we received concerns in relation to the care and welfare and safety of people who lived at the home. As a result we undertook a focused inspection to look into those concerns. This report only covers our findings in relation to those topics. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Oak Cottage on our website at www.cqc.uk

Oak Cottage is registered to provide residential care for up to 21 older people, some of whom live with dementia. There was a registered manager in place however, they did not oversee the day to day running of the service. 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. The service was being run by three assistant managers, two of whom were available on the day of our inspection. However we did speak with the registered manager at the end of the inspection as part of the feedback.

The service provided a welcoming and a homely atmosphere. People told us that they were happy with the care and support they received. Staff knew people well and supported them appropriately. We observed that staff responded promptly to people's request for help and support.

Care Quality Commission (CQC) is required to monitor the operation of the Mental Capacity Act (2005) (MCA) and Deprivation of Liberty Safeguards (DoLS) and to report on what we find. DoLS are put 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, usually to protect themselves or others. At

Summary of findings

the time of the inspection there had been no applications made to the local authority in relation to people who lived at the service even though we were informed by the two assistant managers that there were people who lived at Oak Cottage who did not have capacity to consent. The manager and staff had very limited knowledge or understanding of their role in relation to MCA and DoLS.

Some areas of people's care plans reflected individual needs and gave guidance to staff on how to support people. However, we also found that the care plans did not provide detailed information on how to care for some people's care needs such the management of both pressure care and skin integrity and the spread of infection, nutrition, end of life decisions or a person's ability to make decisions. People were not always involved in decision making about their care. Relatives were approached by the staff at the service who discussed and planned care with the management and staff team.

People did not always receive their medicines as prescribed and not all of the medication records required by legislation were up to date.

We found that the provider's recruitment procedures had not always been followed. This meant that people were potentially put at risk of harm. Staff had not received appropriate and relevant training to be able to meet the needs of the people who used the service.

We found that there were no arrangements in place for regular 'house' meetings to be held. This meant that people were not given an opportunity to express their views on how the service was run or to raise any issues or concerns about the service provided.

At this inspection we found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the provider to take at the back of the full version of the report

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not safe.

People told us that they felt safe at Oak Cottage.

Recruitment procedures were not robust. The manager and staff had limited knowledge in regards to Deprivation of liberty Safeguards.

People had not received the appropriate assessments to ensure that care was planned and delivered in a way that promoted their safety and welfare.

We could not improve the rating from 'Requires Improvement' because to do so requires consistent good practice over time. We will check this during our next planned inspection.

Is the service effective?

Requires Improvement

The service was not effective.

Some people were not supported to receive sufficient amounts of food and drink.

People had access to health care professionals.

Staff had not received up to date and relevant training for their role.

We could not improve the rating from 'Requires Improvement' because to do so requires consistent good practice over time. We will check this during our next planned inspection.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People were mostly positive about their care.

People's privacy and dignity was not always respected and maintained.

People were not involved in their planning care.

We could not improve the rating from 'Requires Improvement' because to do so requires consistent good practice over time. We will check this during our next planned inspection.

Is the service responsive?

Is the service well-led?

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.'

We undertook an unannounced focused inspection of Oak Cottage on 23 January 2015. This inspection was done because we received concerns in relation to the care and welfare of people who lived at the home. The inspection consisted of two inspectors. We spoke with ten people who lived at Oak Cottage and two visiting relatives. We also spoke with members of the staff team which included five care staff, two assistant managers and the registered manager who joined the inspection in the afternoon.

Before our inspection we reviewed information we held about the service including statutory notifications and enquiries relating to the service. Statutory notifications include information about important events which the provider is required to send us.

We observed care and support being provided in the communal areas of the home.

We reviewed a range of records which included staff training and recruitment records, the care plans of nine people and medication records.

Requires Improvement

Is the service safe?

Our findings

We had received some information of concern that related to the care and welfare of people who lived at the home. This included medications not being administered safely which may place people at risk of harm.

There was a system for the management of people's prescribed medicines. We observed the medicine round at lunch time and found that staff administering the medicines explained to the person that it was time for them to take their medicines. We looked at the medicine administration record charts and noted that these had been initialled which indicated that the medicines had been given. People said that they received their medicines regularly and on time.

However, we found that medicines were not being administered safely for example, three people whose medicines were prescribed to be given thirty minutes before food had been given this medicine with their meals. Staff told us that they had followed the written daily routines from people's care plans and were not aware of the instructions on the medicine labels. They were therefore not following the prescriber's instructions or the medicine administration records relating to the people taking the medicine. We noted that there had been no medicines audit done since the last inspection in July 2014 to ensure that safe practices were promoted in the management and administration of medicines. We found that medicines returned to pharmacy for disposal had not been signed by the pharmacist or the driver to indicate that the medicines had been returned to them. We looked at the risk assessment of one person who had been prescribed an anticoagulant medicine. While the risk assessment identified that other signs to observe for such as bruises or cuts, it did not state that 'cranberry juice' can increase the effect of the medicine leading to bleeding problems. We spoke to the staff about this additional risk and they were unaware of it. There was a real risk to this person that they could have been given a drink that could have a negative impact on their health due to a lack of appropriate risk assessments. There were no arrangements in place to monitor, evaluate and manage the risk to this person, appropriately.

This was a breach of Regulation 13 of the Health and Social care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 12 (f) & (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We checked the care records for nine people and found one care plan had recorded that the person had sustained bruising to the back of their neck, after rolling out of bed on 22 January 2015. However there were no records seen which confirmed that this person had been seen by the GP following this incident and no measures in place to reduce the risk of further falls. This person's care plan also contained a monthly MUST [Malnutrition Universal Screening Tool] which was last reviewed in August 2014.

We looked at the records for one person who was being cared for in bed. This person had been provided with a pressure relieving mattress by the district nurse in August 2014. However none of the three [Care] staff we spoke with or the two assistant managers were able to confirm what the correct setting on the device should be, to ensure this person was protected from the risk of developing pressure sores. We were told that they had asked the district nurse to provide this information but had not received any support or advice back from them. However this request was made six months ago and on the day of this inspection the home had still failed to obtain or confirm this information. This meant the delay in ensuring that this person was protected from pressure sores could have placed them at risk of harm.

This was breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 9 (3) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw some of the carpets in the bedrooms were worn, badly stained and uneven. One person told us that they had difficulty when walking across one side of their room to the other due to the uneven floor. Such flooring posed the risks to people of falling and injuring themselves. One of the fire doors on the first floor landing had been locked and the key removed. The manager said that they had taken this action to prevent some of the people who had mobility problems from accessing the stairs and hurting themselves. However, this restriction also prevented others who were

Is the service safe?

able to access the stairs. This posed a fire safety risk and there were no risk assessments in place to ensure that people were safe from the risk of fire considering one of the fire exits was inaccessible.

This was a breach of Regulation 15 of the Health and Social care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw that information about safeguarding procedures was available to staff. They had received training in safeguarding and were aware of their responsibilities to report any allegations of abuse to their managers or alert the relevant authorities such as the local safeguarding team or the Care Quality Commission. People said that they felt safe living in the care home because there were other people around and the staff who looked after them. They also said that the coded gate provided added security as only authorised people were able to come in. One person told us that “Of course I feel safe.” There are very nice people here and they are friendly. I have my own key to help keep my things safe.” There were two people who used bedrails when they were in bed to protect them from rolling out of bed and getting hurt or injuring themselves. We saw that both people had an up to date risk assessment in place which ensured that all the necessary steps to reduce the risk of harm to people had been taken. People told us that if they did not feel safe, they would use the call bells or let someone who was near them know.

Some people told us that there was enough staff on duty to care and support them in meeting their needs. However one person told us that “There could be more staff as often there are only two staff to look after all of us.” Staff confirmed that the staffing levels were sufficient for the number of people living at the care home. They said that in an event that someone was unable to come to work, the managers would contact other staff and ask them to cover. We were told that although staff do answer the call bells “I use the call bell very rarely but they do not always respond in a timely manner because there are too many other people that need help, sometimes I have to wait for up to 10 minutes to get an answer.”

We found that safe recruitment systems were not in place. We checked two staff recruitment records and saw that not all pre-employment checks had been completed prior to these two members of staff commencing employment. One person’s file contained only one hand written reference with no name or signature of the person who supplied this reference. Another record showed that the person had commenced employment using a reference that was a year out of date. There was no evidence available that confirmed that references for these two people had been verified. We were told that references and checks with the Disclosure and Barring service were always carried out prior to the person commencing work. The assistant manager was unable to provide an up to date recruitment policy. This meant people were employed to work in the home without the necessary checks being carried out therefore people who lived within the home could be placed at risk of harm due to unsafe recruitment procedures.

This was a breach of Regulation 21 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We were told by one of the assistant managers that one person had diarrhoea and vomiting and was being ‘barrier nursed’ in their bedroom. We saw that this person's bedroom door had been 'propped wide open' which could have placed people who use the service, staff and visitors at the risk of cross infection. When the daily records were checked there was no information available with regard to this incident or that the GP had been informed, visited or any outcome of their visit or how to care or support this person. There were no written guidelines for staff to follow with regard to how to ensure that this person was cared for in line with infection control standards. Although three staff we spoke with were able to explain verbally, how they cared for this person i.e. the use of gloves and aprons. The home’s most recent infection control policy was dated 2009.This meant that people’s health, welfare and safety was not always maintained or protected.

Requires Improvement

Is the service effective?

Our findings

We had received some information of concern that related to the care and welfare of people who lived at the home. This included people not having access or being provided with adequate amounts of food and fluids.

We found that staff did not always make sure that people were eating and drinking enough to keep them healthy. We saw that one person had been assessed as being nutritionally at risk, but staff had not made the appropriate referral to a dietician or developed a care plan to support this person. Another person had been steadily losing weight since being admitted into the home, but referral to a dietician was not requested until 10 months later. This person's food intake records did not always make it clear how much they had eaten and we saw that staff had sometimes recorded 'biscuits' when the person was supposed to be on a soft diet. This placed this person at risk of choking. Two fluid charts seen had not been 'totalled' up with the amount of fluid intake over each 24 hour period and there were no measuring cups made available for staff to accurately record the amount of fluid each person had drunk. This meant that people were placed at risk of malnutrition and dehydration from not being given adequate amounts of food and fluids.

This was a breach of Regulation 14 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found there was conflicting information within regard to how many people at the home were unable to consent to their care and treatment. During the inspection the management team were unable to agree on how many people did not have the capacity to consent to aspects of their care. We were told by the assistant manager that "Between two and five people did not have capacity." However we found that Mental Capacity Assessments had not been completed for anyone who lived at the home. For example there were no assessments completed for people to consent to personal care, medication or for their photograph to be taken. We discovered that 13 people who lived on the first floor were restricted from moving freely within the home because both connecting doors had been locked. One member of care staff told us that people were not 'allowed' to remain upstairs and everyone had to be downstairs where staff could "keep an eye on everyone." A person using the service told us that "I prefer to have my meals in my room but I am not allowed to." This meant that people's autonomy, freedom and choices were restricted.

The provider did not understand their responsibilities in relation to MCA and DoLS, and had not applied to the local authority for authorisations for anyone, in accordance with the Deprivation of Liberty Safeguards (DoLS) even though they confirmed that there were several people who lived at the home who lacked capacity to consent. We saw that although some of the staff had received training in relation to MCA and DoLS, they were unable to demonstrate their understanding of these requirements and why they were put in place. Therefore the provider was not meeting the requirements of the Mental Capacity Act 2005

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw from the staff records and from speaking with staff that they people had not received regular supervisions with the provider. One person told us that they meet with one of the seniors "Twice a year." Another person was unable to confirm when they last received supervision. Supervisions are necessary to ensure that each staff member's performance, training needs and any concerns are reviewed and monitored on a regular basis. The provider did not have an appraisal system in place to enable them to formally assess each staff member's performance and identify developmental, as well as, further training needs. Although staff had received some mandatory training relevant for their role, three staff we spoke with were unable to confirm when they last received safeguarding training, first aid training, medication training and moving handling training. One person told us that they had received no training since being appointed in 2014. On the day of this inspection an up to date training record that could evidence that all staff had received the required training to carry out their role effectively and safely was unavailable. This meant that people were placed at risk from staff who had not received the appropriate training or support to ensure that they provided care that was both safe and effective.

Requires Improvement

Is the service effective?

This was a breach of Regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 18 (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires Improvement

Is the service caring?

Our findings

We had received some information of concern that related to the care and welfare of people who lived at the home. This included staff failing to maintain people's dignity and privacy.

We saw some staff and people who lived in the home interacting well but people who were quiet were given very little attention. For example one person sat for a period of one hour in the lounge without any interaction or stimulation from any member of staff. We spoke with nine people about the care they received. One person told us "The care is very good here and everyone is very friendly." "I am happy with the service." Another person told us "Some of them [Staff] know me but others don't understand a lot about me. Staff support me well and the food is generally ok." We saw that staff spoke to people in a respectful and caring manner.

The registered manager told us that no one who currently lived in the home had an advocate. We saw that there no information was displayed or available to give to people about how they could find an advocate if they wished to access this service. One person [Relative] told us that they had not been made aware of any advocacy services when their relative had moved into the home but felt they could ask on their behalf if the need came up. This meant people may not be aware of which advocacy services are available to them.

We found that none of the care records seen had an end of life plan in place. In particular one person who was being cared for in bed had nothing recorded within their plan of care with regard to their last wishes or funeral arrangements. There was no evidence that people's preferences and choices for their end of life care had been considered or documented in any of the nine care plans looked at. This meant that people's choice of end of life wishes were not being considered or respected which could lead to inappropriate care being provided.

We received some positive comments from people. One person told us that they "I like all the staff here, they look after me well." Another person explained that when they get upset or feel sad that the staff are always there to comfort them. We spoke with one relative who told us that the staff were all "Marvellous and that the [Relative] was much happier since moving into the home.

People told us that staff always respected their privacy and dignity. However we saw that one person who was receiving personal care had their bedroom door propped wide open which meant that anyone passing by could see into their room. This meant that people's privacy and dignity was not always upheld. Three people we spoke with told us that staff always knocked and waited before they entered their room. One person was able to describe how they maintained their dignity when they bathed them and how "It's hard when you get older and you have to accept help from someone you don't really know, especially with private thing like washing and getting dressed." Two staff confirmed that they had received training on how to maintain people's dignity and privacy when they first started their job. One staff member said that "Although we are often rushed off of our feet, we always make sure people are cared for in a respectful manner and with dignity." However another staff member told us that people do not always get to have a bath each week because "it often takes all morning just to get people up." This meant that people's personal care needs and choices were not always respected and upheld.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw no evidence from the nine care plans we looked at that people who lived at the home or their relatives had been involved or had consented to their plan of care. None of the plans had been reviewed in line with home's policy. For example one person's care plan had not been reviewed since 2013. Two people were unaware that they had a care plan and four people we spoke with told us that they had never seen their plan of their care. This meant that people may not have had their views and opinions on how they wished their care to be provided acted upon.

Requires Improvement

Is the service responsive?

Our findings

Inadequate

Is the service well-led?

Our findings

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 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 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services **Regulation 9 (1) (a) (b) (i) (ii) (iii)** **The service did not assess the needs of people who used the service to ensure their safety and welfare.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010 Safeguarding people who use services from abuse **Regulation 11 (1) (a)** **The registered person had not ensured that staff were suitably trained to enable them to identify the possibility of abuse and respond appropriately.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010 Respecting and involving people who use services **Regulation 17 (1) (a) (b)** **The registered person did not make suitable arrangements to ensure that people were enabled to participate in making decisions in relation to their care.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 21 HSCA 2008 (Regulated Activities) Regulations 2010 Requirements relating to workers **Regulation 21 (1) (a) (i) (ii)**

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff Regulation 23 (1) (a) The registered person did not ensure there were suitable arrangements in place to ensure that persons employed received the appropriate training to enable them to provide care or support to people safely and to the appropriate standard.
	The registered person did not operate effective recruitment procedures in order to ensure a person employed was of good character and had the qualifications, skills and experience necessary for the work to be performed.