Care Quality Commission

Oldfield Manor Limited

Oldfield Manor

Inspection report

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Ratings

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

Overall summary

We carried out this inspection on 08 January 2015 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 was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008.

The service is registered to provide nursing or personal care for 17 elderly people. On the day of the inspection 15 people resided within the home.

We last inspected this service in January 2014 when the service met all the standards we inspected. This unannounced inspection took place on the 08 January 2015.

The service had a registered manager. 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 a legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Summary of findings

People who used the service told us they felt safe and felt able to voice any concerns to the manager, staff or their families.

The Mental Capacity Act 2005 (MCA 2005) sets out what must be done to make sure the human rights of people who may lack mental capacity to make decisions are protected. The Deprivation of Liberty Safeguards (DoLS) provides a legal framework to protect people who need to be deprived of their liberty to ensure they receive the care and treatment they need, where there is no less restrictive way of achieving this. Staff understood their responsibilities under the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards (DoLS). We found action had been taken where necessary to ensure people's capacity to make their own decisions had been assessed. Where any restrictions were in place we found these were legally authorised under the Mental Health Act 1983 or with people's consent.

Staff were recruited using current guidelines to help minimise the risk of abuse to people who used the service.

People had signed their consent to agree to their care, treatment and the administration of medication. People also signed to say they had received key documents such as the statement of purpose, service user guide, terms and conditions and the complaints procedure. We have made a recommendation to record people's permission before taking their photograph for identification purposes in documents such as care plans or medication sheets.

The environment was well maintained and people were able to help choose the décor or furnishings to make the environment more homely to them.

Staff told us they received a recognised induction, completed enough training to feel confident in their roles and were supervised. Staff felt supported at this care home.

People's needs were regularly assessed and updated. Staff were updated at each shift at their handover sessions.

The administration of medication was safe, staff competencies were checked and the system audited for any errors by the registered manager and the local pharmacy.

People who used the service, staff and other agencies were asked for their views about how the service was performing. We saw that the registered manager had taken action to provide a better service from the views such as updating the décor and improving the laundry service.

The registered manager audited systems at the home, including infection control and the environment. Gas and electrical equipment was maintained to help keep people safe.

The service used external agencies such as age concern to try to improve activities. As a result 7 people attended a computer course to learn how to access social media to help them keep in touch with family and friends. Other activities were provided to help keep people stimulated.

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?

Good

The service was safe. People we spoke with said they felt safe. The service had previously notified the authorities of any possible safeguarding incidents. There were systems in place for staff to protect people. Staff had received safeguarding training and were aware of their responsibilities to report any possible abuse. Staff used the Blackburn with Darwen adult safeguarding procedures to follow a local protocol.

Arrangements had been made to ensure the gas and electrical equipment and supply was maintained in good working order.

There were safe systems for the ordering, administration, storage and disposal of medicines.

Is the service effective?

Good

The service was effective. This was because staff were suitably trained and supported to provide effective care.

Staff understood their responsibilities under the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards (DoLS). People were not restricted in the home unless this was legally authorised.

People were given a choice of food to help ensure they received a nutritious diet. All the people we spoke with said food was good.

Is the service caring?

Good

The service was caring. People who used the service thought staff were helpful and kind. Two visitors we spoke to thought staff looked after their relative in a caring manner.

We observed staff during the day. Care was given privately and people were treated with dignity. Staff talked to people in a professional and friendly manner. People who required help were given assistance quickly.

Is the service responsive?

Good

The service was responsive. People who used the service, or where appropriate a family member were involved in their care and care plans. Plans of care contained sufficient personal information for staff to meet people's health and social care needs.

There was a suitable complaints procedure for people to voice their concerns. The manager responded to any concerns or incidents in a timely manner and analysed them to try to improve the service.

Is the service well-led?

Good

The service was well-led. There were systems in place to monitor the quality of care and service provision at this care home.

During meetings and by sending out questionnaires the service obtained and acted upon the views of stakeholders, families and people who used the service.

Summary of findings

Healthwatch Blackburn with Darwen and the local authority contracts and safeguarding team did not have any concerns about this service.

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Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 08 January 2015 and was unannounced. During the inspection we spoke with 8 people who used the service, 5 visitors, 5 care staff and the registered manager.

The membership of the inspection team consisted of one 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 service. The expert was experienced with people who had a learning disability.

Before this inspection we reviewed previous inspection reports and notifications that we had received from the service. As this inspection was undertaken at short notice we were not able to request a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and any improvements they plan to make.

We asked Blackburn with Darwen Healthwatch and the local authority safeguarding and contracts departments for their views of the home. The views were positive.

During the inspection we observed care and support in the communal areas of the home. We looked at the care records for three people who used the service and medication records for seven people. We also looked at a range of records relating to how the service was managed; these included training records, quality assurance audits and policies and procedures.

Good

Is the service safe?

Our findings

The eight people we spoke with said they felt safe. People who used the service told us, "I am safe and they look after me instead of trying to do it for myself at home" and "I do feel safe here. This place is splendid and I can't really criticise". A visitor said, "In my opinion this home is the best she has been in and I am confident she is safe and cared for".

Staff had completed safeguarding training and the two staff spoken to about safeguarding were aware of what and how to report safeguarding incidents. There was a company safeguarding policy and procedure and a copy of Blackburn with Darwen social services procedures to follow local protocols. The safeguarding policy told staff what constituted abuse and how to respond and report any concerns. There had not been any safeguarding incidents since the last inspection. There was a whistle blowing policy for staff to feel confident they would not be penalised for reporting concerns.

People who used the service told us they thought there were sufficient staff on duty and we observed people being attended to promptly. On the day of the inspection there was the registered manager, a senior care staff and care staff member, the cook, domestic assistant and for part of the day a maintenance man. We looked at the off duty and saw this was normal. The night shift was covered by two staff with one sleeping in after midnight if it was quiet. Three people required two care staff to assist them. Staff told us, "There are usually 3 or 4 staff on duty and if we are short for any reason then we work overtime as necessary" and "There are enough staff and we cover for each other in sickness." The registered manager told us at the present time she thought there were enough staff and she could contact her manager if she required more.

All the people we spoke with said they got their medicines on time with one person commenting, "They are good with my medicines which I don't think I would be taking if it was left to me."

There was a medicines policy which informed staff of the correct procedures for ordering, storing, administration and disposal of medicines. We looked at the policy and saw it matched the process staff followed. All staff who administered medicines had been trained. The registered manager and pharmacy who supplied the home audited the system to check staff competency. The care home used the bio-dose system. This system contained the persons photograph on the front sheet for identification purposes, the details of the medication, the dosage and time to be given. Staff then had to sign to say they had given the medication.

Each person who used the service had signed an agreement for staff to administer their medicines.

We looked at seven medicines records and saw that staff had completed the forms correctly and signed them. Two staff signed for any hand written prescriptions to minimise errors. One staff signed for any other medicines entering the home and counted the totals to show administration was accurate. The temperature of the medicines room was checked and recorded to ensure medicines were stored safely. Some medicines needed to be kept cool and this was stored in the fridge and the temperature was also recorded. We observed the lunch time medication round and saw that the staff member correctly administered medicines one person at a time and keeping the trolley secure.

The trolley was secured to the wall when not in use and other medicines were stored in a secure room.

Staff had access to reference material such as the British National Formulary and medicines advice sheets to be able to detect possible side effects. The reason and dose of 'as required' medicines was clearly recorded to ensure staff knew what they were for and when to give it.

Nobody was currently on controlled drugs although there was a suitable cabinet and register. There was a safe system to dispose of unwanted or unused medicines. Staff who administered medicines signed a signature list to enable the manager to safely audit the system and follow up on any errors.

There was an infection control policy and the registered manager conducted regular audits to check for cleanliness and faults. The staff training matrix showed staff had completed infection control training. The laundry was separate from any food handling areas and contained sufficient equipment to provide a good service. The service also had a copy of the current health authority infection control guidelines for care homes for staff to follow good

Good

Is the service safe?

practice. There were hand washing facilities around the building for staff to use and prevent the spread of infection. Staff had access to protective clothing such as gloves and aprons and we saw staff using the equipment at lunchtime.

We saw that all the gas and electrical equipment had been serviced and checked. This included the fire alarm system, electrical installation, gas appliances, portable electric appliances, fire extinguishers and emergency lighting. There was a contract for the disposal of contaminated waste and the water outlets were treated to prevent Legionnaires disease. The fire system and procedures were checked regularly to make sure they were working and each person had an emergency evacuation plan. Staff told us they had been trained to use any equipment provided at the home such as the hoists and slings.

The lift and hoists were serviced and maintained. The fire alarm points were checked regularly to ensure they were working correctly. Hot water outlet temperatures were checked to ensure they did not scald people and windows and radiators were safe.

Each person had a personal evacuation plan to help staff assist people who used the service to get out of the building in an emergency such as a fire. This was reviewed to ensure it was effective.

We looked at two staff files. The staff had been checked for their suitability to work with vulnerable people. The checks included a criminal records check (now called disclosure and barring), two written references, an application form where the manager could explore any gaps in employment and a person's proof of address and identity. This helped ensure new staff did not pose a threat to the people accommodated at the home.

Good

Is the service effective?

Our findings

Residents and visitors told us the home was clean and tidy. We toured the building on the day of the inspection, visited all communal areas and 8 bedrooms. The home was warm, clean, homely and did not contain any offensive odours.

The décor was suitable for the people accommodated at the home. The lounge was split into two areas with a television on both sides. One lounge was used by several people and one man sat on his own said he preferred his own company. There was sufficient seating for all and a variety of styles to suit people's tastes.

The dining room had sufficient tables and seating to cater for the people accommodated at the home and condiments were available for people to flavour their food. It seemed people had their 'regular' places.

Bedrooms we visited had been personalised to people's tastes including ornaments and photographs. They had sufficient clean bedding and furniture to be able to stay in their rooms with comfort. People were able to go back to their rooms if they wished.

There were three places people could bathe or shower dependent upon their preference. There were different types of hoisting aids for people who required help to get in and out of the bath. A wet room also contained a specialised bath.

There was some signage to help people around but we saw that most people came and went to their rooms or used the toilets without any confusion. There were also aids in the toilet, grab rails if people needed some support and a lift to access both floors.

There was a conservatory which people seemed to use regularly during the day and a garden to the front of the property for people to use in good weather.

We sat with people who used the service at lunchtime. The tables were nicely set with ornaments. All six people we spoke with said they had enjoyed their lunch. Comments included, "I can't fault the staff, the care or the food", "The food is good" and "The food is ok and you get lots of choice." There was a four weekly menu cycle. People could have what they wanted for breakfast (cereals, toast or cooked food), a choice of two meals and sweets at lunch time and a choice of meal and sweet at tea time. People also had a supper. A selection of drinks were served throughout the day, both hot and cold options. There was a good supply of fresh fruit and vegetables.

During lunchtime we observed good interaction between staff and people who used the service. People were asked if they had eaten enough and one person had more. The expert by experience was asked if he would like a meal and commented that it was very good afterwards.

Two people required assistance to eat and we observed that staff did this in an individual and discreet manner and sat and talked with the people they assisted.

The kitchen had been awarded the 4 star good rating by environmental health which meant food was stored and served safely. The cook undertook necessary checks and the cleaning of the kitchen. This included a record of the meal people had taken so an audit could track any possible problems with illness associated with food production. The cook said she could produce special diets such as low salt or sugar and there was a list in the kitchen of the diets people needed.

The Mental Capacity Act 2005 (MCA 2005) sets out what must be done to make sure the human rights of people who may lack mental capacity to make decisions are protected. The Deprivation of Liberty Safeguards (DoLS) provides a legal framework to protect people who need to be deprived of their liberty to ensure they receive the care and treatment they need, where there is no less restrictive way of achieving this. Key staff had been trained in the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards. We inspected three plans of care during the inspection. Each person had a mental capacity assessment using the current forms and were deemed to have the capacity to make decisions for themselves. We saw this assessment had been completed in accordance with the principles of the Mental Capacity Act. The assessments were reviewed yearly or earlier if required. One person had a relative who acted as an advocate should her mental health deteriorate. An advocate is a person who will act upon a person's behalf to protect their rights and act in their best interests. The registered manager said, "We assess each person who is admitted to the home. I would follow the policies and procedures if we had to make a best interest decision. I would also take advice from one of the other group home managers who has been involved in best interest's decisions for people."

Good

Is the service effective?

We inspected three plans of care during the inspection. Prior to admission staff would visit people to assess their care and treatment requirements. During the process staff would gain as much information as they could from the person, family member or involved professionals. Social services usually provided an assessment of their own. People were invited to come to the home, meet other service users and take a meal if they wished. From the information staff gained a plan of care was developed if staff at the care home thought they could meet people's needs.

The plans of care were individual to each person. We saw there was a 'map of life' document which told us about a person's past life, work and social history and a 'this is me' section which give us information about a person's choices and preferences. The care plans was divided into separate sections for needs such as moving and handling, nutrition and pain. One part of the plan gave staff information about end of life care. There were 14 sections of the plan and various other documents such as a record of the professionals who attended each person. People had signed their agreement to their care and treatment, permission for staff to administer medicines and documents including the service user guide, terms and conditions and the complaints procedure. We recommend that the service also seek permission to take photographs for identification purposes in care plans and medicines records. Plans of care were updated regularly to keep staff up to date with people's health and social needs.

Plans of care contained risk assessments for nutrition, tissue viability (the possibility of developing a pressure sore), moving and handling and the possibility of falls. There were also environmental risk assessments, for example, going out alone or using public transport. The risk assessments were reviewed regularly and were to keep people safe and not place unnecessary restrictions upon them.

We saw that people had access to specialists and professionals. They included mental health specialists, opticians, chiropodists, dentists and nurses. Each person had their own GP. We saw that regular multi-disciplinary meetings were held for people with mental health problems. These meetings call together all the professionals involved in a person's care to discuss and agree on the best treatment they can provide.

New staff had to undertake an induction prior to being able to work with people who used the service. Staff were shown key policies and procedures and shown around the home to view the facilities and environment such as fire escapes. There was a reliable staff team and no new starters for some time. However, we were told (as in other group homes) that staff would be enrolled on a skills for health and social care induction as soon as possible. Staff also told us new starters were shadowed until it was felt they were competent to work with vulnerable people.

We looked at the training matrix, staff training program and two staff files during the inspection. There was a yearly cycle of training which included safeguarding, mental capacity, infection control, health and safety, tissue viability, customer care, stroke awareness, equality training, fire awareness, person centred support, first aid, managing violence and aggression, understanding dementia, fire safety, palliative care, food safety, nutrition and well-being, medicines administration, fire safety, moving and handling and Deprivation of liberties. This ensured staff received sufficient training or refresher courses. Staff files contained certificates of attendance. Some staff had also completed a course in health and social care such as an NVQ or diploma.

Staff files contained records of supervision and appraisal. Supervision was usually held around every month. Supervision included care practice, training needs and relevant information. Staff told us it was a two way process and they could bring up any topics they wanted to.

Good

Is the service caring?

Our findings

People who used the service told us, “I am happy and the staff are nice to me. I like it here but I don’t like questions” (we did not ask this person any further questions), “This place is splendid and I can’t really criticise”, “The care is good”, “I’ve been in here more than a year and they are alright”, “These people are brilliant and they’ve saved me from myself” and “I can’t fault the staff, the care, or the food.”

Visitors said, “One of the ways in which this home is better for my sister is that they really do treat her well and I can tell she is more at ease than she ever was previously” and “My wife and I are confident that she is being looked after properly. We only visit periodically but my sister in law comes at least once a week and keeps us informed.”

We observed staff interacting with people who used the service. Staff were attentive, kind and professional. We observed that both people who used the service and staff were aware of privacy issues and any assistance given was discreet. Staff were also trained in confidentiality issues to help keep care and treatment private.

Staff told us they knew people who used the service well and were able to sit and talk to them from time to time.

We saw that a person’s religious preferences were recorded in the plans of care although nobody was attending church at the time. The registered manager said people could attend their church of choice if they wished.

Staff were taught about equality and diversity which should enable them to meet people’s needs from different cultures and backgrounds.

Good

Is the service responsive?

Our findings

People who used the service told us, “They do try to get things going but I prefer to read or watch TV. They have meetings and they change things if we want them to” and “I’m not sure I’m bothered about activities but my sister visits me and I enjoy that.” A staff member told us, “I am a senior support worker and I double as the hairdresser. I love the job and I also do my best with organising activities. I talk to the residents all the time but it is very hard to get them to join in with anything.” Most of the people at this home had a mental health problem and from talking to them and observing their day it was apparent for most people that they preferred their own company. The conversation during the day was mostly with staff. We did see people watching television, reading, listening to music and talking to their visitors.

Activities on offer included exercise given by an outside agency, a martial arts type exercise called Tai Chee, musical afternoons, arts and crafts, film evenings and organised special events for days such as Christmas and Easter. The service had bought a games console and some people used this to play interactive games. Every Tuesday seven people who used the service were attending computer lessons This was to help people correspond with relatives from further afield using modern technology such as Skype. People also went out on trips or shopping. As part of our inspection we asked what the service had improved upon. The registered manager told us, “We talk to age concern to provide us with advice on how we can improve or provide stimulation using different activities”.

Visiting was unrestricted and visitors told us staff were welcoming. People were able to go to their rooms to see their relatives and friends in private if they wished. People who used the service said they were encouraged to visit their relatives.

There was a maintenance book for staff to record any faults or broken equipment and a person employed to replace or fix the equipment.

There was a complaints procedure and people signed to say they had received a copy. The procedure told people how to complain, who to complain to, the time they could expect a reply and how to take it further if they wished. The Care Quality Commission had not received any complaints since the last inspection. People who used the service did not have any concerns on the day of the inspection. Staff told us how they would respond to any concerns by either dealing with simple matters themselves or referring people to the registered manager. The registered manager said they had not received any formal complaints and was available during her shifts for people to talk to if they wished.

People who used the service were regularly invited to meetings given the opportunity to bring up topics they thought important. One person told us the meals were changed after one meeting. We looked at some of the records for the meetings. Topics included activities, Christmas arrangements, taking people Christmas shopping (which had been arranged), bringing in more outside entertainers and the menu. The cook asked everyone what they wanted on the menu. At another meeting people were asked and given the opportunity to pick the lounge carpet. The new carpet had been chosen and was in place when we inspected.

The registered manager said basic information details and medication records could quickly be provided in an emergency to provide other organisations with the basic information they would require.

Good

Is the service well-led?

Our findings

There was a registered manager at the home. People who used the service and family members/visitors told us they felt able to talk to the registered manager or other members of staff if they needed to. On the day of the inspection people told us they thought the manager was approachable and involved in the daily running of the home. No-one had made any complaints formally but all felt sure that management would listen to them should they need to.

There was a recognised management system which staff understood and meant there was always someone senior to take charge. The staff we spoke with were aware that there was always someone they could rely upon. Staff told us, "There is a good team spirit, open and friendly. We all support each other" and "The manager is fair and approachable."

The registered manager was aware of and had sent prompt notifications to the Care Quality Commission and other organisations if required.

There were policies and procedures for staff to follow good practice. We looked at several policies which included infection control, accident recording, advocacy, people's rights, handling violent or aggressive behaviour, complaints, confidentiality, covert medication, safeguarding, reporting drug errors, end of life care, health and safety, the ordering, storage, administration and disposal of medication.

There were regular staff meetings. Topics included ways to improve the service and to inform staff of any changes. We looked at the records and saw that taking people out, ways to improve the laundry service, updating of care plans, the new forms to be completed for falls and a food safety allergens list and advice had been on the last agenda. Staff told us they could contribute to the meeting with any ideas they had.

Accidents and incidents were minimal but we saw that on occasion some people's behaviour may be difficult. This was recorded and ways to minimise any risks or further problems were updated to the plans of care for staff to follow good practice.

Senior staff held a handover meeting with care staff at the beginning of every shift to pass on relevant details about people's care and treatment.

The service sent out quality assurance questionnaires to stakeholders, staff, family members and people who used the service. People who used the service were asked questions around the environment, cleanliness, staff attitude and competence and management. The results were positive but people who used the service said the communal areas were too plain. The registered manager's action plan included redecoration and people were to be given the choice of colour schemes. The carpet had already been replaced. People were also asked to complete a survey a few weeks after admission to ensure they were receiving the care they needed. We looked at three of the surveys which were retained within the plans of care and saw people were satisfied with their care.

Staff were asked questions around training, management and team spirit. The answers were positive and the manager produced a summary with actions to take on any issues raised.

Stakeholder questions were around staff being available, welcoming, knowledge, care, how staff take on board advice and any complaints (all respondents said they never had any complaints). The results were positive but again in the summary with one question not being as good as the manager wanted staff were told to ensure a senior member of staff was told when a doctor was present.

Families thought staff were professional, friendly, kept them informed, the home was clean, satisfactorily decorated and they were involved in care planning.

The registered manager conducted audits to ensure systems, care and treatment remained at a good level. We looked at audits for plans of care, equipment such as hoists and slings, water temperatures, medication, the environment, which checked emergency exits, decoration and bedrooms to ensure all equipment was in working order and the room was clean, the cleaning rota and infection control.

The registered manager said the key achievements for the service were keeping people happy, no concerns or complaints and good relationships with professionals. Things she felt restricted the service were low funding and the constraints of an old building.