Oakfields Care Limited

Loring Hall

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**

Summary of findings

Overall summary

We carried out an unannounced comprehensive inspection of this service on 03 and 05 November 2015 at which we found the provider was meeting legal requirements. After that inspection we received concerns in relation to the management of risks to people using the service. As a result we undertook an unannounced focused inspection on 28 April 2016 to look into those concerns. This report only covers our findings in relation to this topic. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for (location's name) on our website at www.cqc.org.uk.

Loring Hall provides accommodation and personal care support for up to 16 adults. At the time of this inspection, the service was provided to 13 adults with learning disabilities. There was a registered manager in place at the time of our inspection. 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.

At this inspection we found breaches of regulations because risks to people had not always been assessed and there was not always adequate guidance in place for staff on how to manage risks. We also found areas of risk relating to the environment were not always safely assessed or managed, and that people had not always received their medicines as prescribed. Medicines storage areas were not monitored to ensure medicines were stored at a safe temperature. There was insufficient guidance in place for staff on when they should administer medicines that had been prescribed as being 'as required' and records relating to the administration of people's medicines had not always been accurately maintained. We also identified a further breach of regulations because staff had not always received sufficient specialist training relevant to people's conditions. You can see what action we told the provider to take at the back of the full version of the report.

There were sufficient staff on duty to meet people's needs and people commented positively about the support they received.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Risks to people had not always been assessed and some risks to people were not always safely managed.

Medicines were not safely managed and had not always been administered as prescribed. The administration of people's medicines had not always been accurately recorded.

There were sufficient staff deployed within the service to meet people's needs.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff had not always received sufficient training in specialist areas to meet people's needs.

Loring Hall

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 Loring Hall on 28 April 2016. This inspection was done to check on concerns we had received regarding the management of risks to people using the service. The team inspected the service against parts of two of the five questions we ask about services: 'Is the service safe?' and 'Is the service effective?' This is because we identified specific areas under these two key questions as being relevant to the concerns we received.

Before the inspection we looked at the information we held about the service including information from any notifications they had sent us. A notification is information about important events which the provider is required by law to send us. We also spoke to a local authority commissioning team involved in monitoring the service and the local safeguarding team to request their feedback on the service. We used this information to help inform the planning of our inspection.

The inspection was undertaken by an inspector and a specialist advisor with expertise in the area of epilepsy. During our inspection we spoke with three people, three staff, the registered manager and the nominated individual. We reviewed records, including the care records of seven people as well as other records relating to the management of the service. We also undertook a review of the environment and observed staff interactions with the people they supported.

Requires Improvement

Is the service safe?

Our findings

We conducted this inspection in response to concerns we received related to the management of risks to people using the service and we did not look at every aspect of the key question. We found that some risks to people had not always been assessed by the provider, and assessments did not always include adequate information about the control measures used to manage identified risks. For example, we found that one person had no risk assessment or support planning in place around the management of their epilepsy, a condition identified as an area of risk by the commissioning Community Learning Disability Team in their assessment of the person's needs. Although two staff we spoke with were aware that the person in question had epilepsy, senior staff, including the registered manager were not aware of their condition when we raised it with them. In another example, we found that one person's epilepsy risk assessment made reference to the need for staff to refer to the epilepsy protocol in the person's support plan but the registered manager confirmed that the protocol in place was an old document that lacked detail and needed review. This placed the person at risk of receiving inadequate support around the safe management of their epilepsy.

Risks had been assessed for people in areas including slips, trips and falls, eating and drinking, personal care, going out from the service and being alone in their room. Staff we spoke with were aware of these risks and could describe the support they provided to manage these safely. However we found that risk assessments had not always been reviewed within the last six months, in line with the provider's policy. Therefore we could not be assured that the assessments were fully reflective of people's current needs.

Risks to people were not always safely managed. During our inspection we observed two large pans had been left unattended and were boiling on the front rings of the hob in the downstairs kitchen which was an area some people could access unsupported. This placed people identified as being potentially prone to seizures at risk of scalds and/or burns should such an incident occur in that area. We also found that windows that opened onto significant drops were not always securely maintained, placing people at risk of injury from falls.

We also noted that a central stairwell within the service posed a risk to people who were unstable on their feet or subject to seizures, because the handrail on one side stopped at a point several stairs from the bottom and opened onto a large window. We spoke to the registered manager about this and they told us the stairwell was only used by one person who was supported by two staff when moving up or downstairs. She explained that the door at the top of the stairs was kept locked at other times to prevent use. However, we had found the door unlocked earlier in our inspection which meant that people may have been able to access the stairwell from upstairs without support.

These issues were a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities Regulations 2014). The registered manager took action to update the support plan and risk assessments for the person they were not aware had epilepsy during our inspection. The provider was also able to demonstrate that they were in the process of improving the security of the windows at the service and confirmed that the room in question would remain locked until the work to do so had taken place. The

registered manager also told us they would look to ensure other risk assessments were reviewed although we were unable to check on this at the time of our inspection.

Medicines were not always managed safely. Although medicines were securely stored, temperature checks of the medicines storage areas had not been undertaken to ensure they were kept with a safe temperature range. One staff member responsible for administering medicines at the service was also not aware of the maximum safe temperature range for the safe storage of medicine. This meant we could not be assured that people's medicines had been stored appropriate temperatures to ensure they remained effective.

Medicines were not always administered as prescribed and guidance was not always in place for staff on the administration of some people's medicines. We found that on two days within the previous month staff had administered a second dose of a medicine for one person, despite the instructions on their Medication Administration Record (MAR) stating that a maximum of one dose should be administered each day. These incidents had been picked up by staff at the time and action taken to ensure the person's safety. However, we also noted that there were no protocols in place to advise staff when, and under what circumstances people should receive any medicines that had been prescribed 'as required'. This meant there was a risk of such medicines being administered inappropriately.

The administration of people's medicines had not always been accurately recorded. For example, we found that one person's MAR chart had not been signed for a dose of one of their medicines during the week prior to our inspection, although staff we spoke with told us that the dose had been given at the correct time. We also found inaccuracies in the recording of the administration of some people's 'as required' paracetamol which meant we were unable to determine whether some tablets were missing or had been administered. Where prescribed medicines were to be used within 28 days of opening, we found that the date of opening had not always been recorded. This meant there was a risk that they could be administered after the 28 day period had expired when they may no longer be effective.

These issues were a further breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities Regulations 2014). The registered manager took action during our inspection to implement a protocol for one person's 'as required' medicine and told us they would implement them where required for other people as well. They also told us that they would arrange for the staff involved in the misadministration of one person's medicines to be reassessed although we were unable to check on these areas at the time of our inspection.

The provider had already started taking action to address areas of risk identified in response to an incident within the service. We saw an external lock had been fitted to a communal bathroom on one floor which only staff could access, and the provider was in the process of fitting shut off valves to water pipes leading to the other baths in the service. This action reduced the level of risk to people who may require support or supervision whilst undertaking their personal care.

However, we found improvement was required to ensure other areas of risk had been considered by the provider to ensure that people were protected whilst their freedom was supported and respected. For example, the provider had not always considered equipment options available to people with epilepsy which may help to protect them from harm in the kitchen and bedroom. We spoke to the registered manager about this and they told us that people may resistant to some equipment because they may see it as being restrictive or unwanted. However, the use of such equipment had not been assessed in line with people's views and their capacity to make such decisions about their safety.

Improvement was also required to ensure risk assessments contained adequate detail and guidance for

staff on how to safely support people. For example, people's epilepsy risk assessments did not include a detailed profile of their seizure type or activity. In one case we noted that a person had not had a seizure in over 10 years and if they were to have one after such a long period, it would be appropriate to seek clinical input as it could be considered to be a significant incident. However there was no clear guidance about this in their risk assessment.

We also found that staff were aware of the areas in which people were at risk and the action to take to ensure their safety. For example, we noted that one person's risk assessments identified that they were at risk of choking whilst eating and of malnutrition due to self-neglect. Staff were aware of these areas of risk and we observed staff cutting up the person's food when serving them their meal and monitoring their food and fluid intake in line with the control measures identified in their risk assessment.

There were sufficient staff deployed within the service to meet people's needs. One person told us, I feel quite safe here; the staff are lovely." They confirmed that they had no concerns about the staffing levels and that they had the support they required when they needed it. Other people did not comment directly on the staffing levels but we observed them to be relaxed and comfortable in the presence of staff who were on hand to support them when required.

Staff we spoke with told us that they had no concerns about staffing levels. The registered manager confirmed that staffing levels were determined based on an assessment of people's needs and that senior staff were also available to provide additional support where required in response to any incidents. We observed that the current staffing levels were reflective of people's needs. For example, we saw that one to one support was in place where this level of staffing was required to keep people safe.

Requires Improvement

Is the service effective?

Our findings

We conducted this inspection in response to concerns we received relating to the management of risks to people using the service. As part of our inspection into this area we reviewed information about staff training. One person we spoke with commented, "Staff know how to support me." However, despite this feedback we found that staff had not always received training in areas specific to people's conditions.

Staff had received training in areas including health and safety, first aid, the use of physical interventions and safeguarding. However, the registered manager confirmed that seven people using the service had epilepsy and told us that epilepsy training was mandatory for staff but confirmed that 14 staff required or were overdue refresher training in this area, and 24 staff required or were overdue refresher training around the administration of specific epilepsy medication. Training records also showed that none of the staff outside of the management team had received training relating to autism, despite the service providing support to people with this diagnosis.

These issues were a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities Regulations 2014). The registered manager was taking action to arrange relevant epilepsy training for staff at the time of our inspection and told us they would arrange autism training as well, although we were unable to check on the outcome of this at that time.

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 12 HSCA RA Regulations 2014 Safe care and treatment Risks to people had not always been assessed and action had not always been taken to mitigate identified risks. Regulation 12(1)(2)(a)(b). The premises was not safe. Regulation 12(1)(2)(d). Medicines were not safely managed. Regulation 12(1)(2)(g).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staff had not always received sufficient training to carry out their duties. Regulation 18(1)(2)(a).