Bupa Care Homes Limited

Oakhill House Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

We inspected Oakhill House Care Home on the 3 November 2017 and the inspection was a focused inspection. Oakhill House Care Home is situated in the town of Horsham. The service provides nursing care and support for up to 49 older people, most of whom are living with dementia. On the day of our inspection, there were 39 people living at the service. There are four communal lounges, two dining rooms and well maintained gardens.

The service did not have a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. A manager was in post on the day of the inspection and they had been in post four weeks. They told us that they would be submitting an application to become the registered manager and subsequent to the inspection, we were informed that the manager had submitted an application to become the registered manager.

At the last inspection undertaken on the 19 and 20 June 2017, the provider was in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014. This was because accurate and complete records had not been maintained. Recommendations were also made in relation to the administration of medicines. The provider sent us an action plan stating they would have addressed these concerns by October 2017. We undertook this focused inspection to check that they had followed their plan and to confirm that they now met legal requirements. This report only covers our findings in relation to those requirements. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Oakhill House Care Home on our website at www.cqc.org.uk

The inspection was prompted in part, by a notification of a serious injury involving a person who lived at the service. The incident is subject to an investigation and as a result this inspection did not examine the circumstances of the incident. However, the information shared with CQC about the incident, indicated potential concerns about the management of risk in relation to falls.

The management of falls was not consistently safe. The provider was not consistently following their internal falls protocol and procedure. Where people had been assessed at high risk of falls, falls care plans were not consistently in place. Guidance did not always document the measures required to mitigate the risk of people falling.

Steps had been taken to drive improvement and the provider was now meeting the legal requirements. The administration of medicines was safe and care documentation had improved. However, further work was required to strengthen the provider's internal quality assurance framework. The care planning process failed to consistently identify and reflect how staff respected and upheld people's equality and diversity. Care plans failed to consistently identify people's involvement with the design and formation of their care plan. Systems were in place to determine staffing levels. Steps had been taken to recruit additional staff and the

use of agency staff was reducing. However, staff members felt staffing levels were insufficient and a struggle. We have identified these as an area of practice that needs improvement.

Staff worked in partnership with other healthcare professionals to promote good outcomes for people. Where people displayed behaviours which challenged, staff completed behavioural observation charts; however, the findings from the behavioural charts did not consistently feed into the care plan and risk assessments. We have identified this as an area of practice that needs improvement.

People were protected from harm and abuse. There were appropriate, skilled and experienced, permanent staff who had undertaken the necessary training to enable them to recognise concerns and respond appropriately. Staff were checked before they started working with people to ensure they were of good character and had the necessary skills and experience to support people effectively. There was a whistle-blowing procedure available and staff said they would use it if they needed to. People's medicines were managed appropriately and people received their medicines as prescribed by health care professionals.

Systems were in place to gain feedback from people, staff and relatives on the running of the service. Staff successes were celebrated. The service was subject to a period of change and the senior management team were dedicated in supporting staff, people and their relatives through the period of transition.

A dedicated team of housekeepers were available and systems were in place to prevent the risk of infection. Infection control policies and procedures were in place alongside plenty of personal protective equipment (PPE). Risks associated with the environment were managed and people's ability to evacuate the building had been considered and assessed as part of the service's fire safety risk assessment.

During our inspection we found one breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the registered provider to take at the back of the full version of the report.

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

Oakhill House was not consistently safe.

The management of falls was not consistently safe. Staff felt staffing levels were stretched and not sufficient.

Staff had a clear understanding about how to protect people from abuse. People received the medicines safely when they needed them. There were robust recruitment procedures in place.

Risks associated with the environment were mitigated and people were protected against the risk of infection.

Is the service well-led?

Requires Improvement

Oakhill House Care Home was not consistently well-led.

The service was subject to a lot of upheaval. The provider's internal quality assurance framework required strengthening. Shortfalls with documentation had not been identified internally as part of the provider's quality assurance checks.

Links with the local community had been established and the service worked in partnership with external healthcare professionals. Staff successes were celebrated.

Oakhill House Care Home

Detailed findings

Background to this inspection

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

We undertook an unannounced focused inspection of Oakhill House Care Home on 3 November 2017. This inspection was carried out following a safety incident at the service. The team inspected the service against two of the five questions we ask about services: is the service safe and is the service well-led? The inspection was carried out by two inspectors, a specialist nurse advisor 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 service was last inspected in June 2017 where areas of improvement were needed in relation to the administration of medicines, provision of meaningful activities and documentation. The service was rated as 'Requires Improvement'.

The provider had not completed a Provider Information Return (PIR), because we had not requested one before this focused inspection. This is a form that asks the provider to give some key information about the service, what the service does well and the improvements they plan to make. Before the inspection we reviewed all the information we held about the service; we looked at previous inspection reports and any notifications received by the Care Quality Commission. A notification is information about important events, which the provider is required to tell us about by law.

We spoke with the home manager, regional support manager, regional director, clinical lead, deputy manager, registered nurse, a house keeper, the activity coordinator, five members of care staff, five people who used the service and seven visiting relatives.

We looked at seven care plans and the associated risk assessments and guidance. We looked at a range of other records including medicines records and audits, maintenance records, three staff recruitment files and staff rotas. We observed people receiving their morning medicines.

Requires Improvement

Is the service safe?

Our findings

People told us they felt safe living at Oakhill House Care Home. One person told us, "The best thing about here is it's safe and they always make sure you are okay." Visiting relatives also confirmed they felt confident leaving their loved ones in the care of Oakhill House Care Home. However, despite people's positive comments, we found areas of care which were not consistently safe.

At the last inspection in June 2017 we identified areas of improvement in relation to the administration of medicines. A recommendation was made and at this inspection, we found improvements had been made.

Oakhill House Care Home provided care and support to some people living at high risk of falls. Guidance produced by the National Institute for Health and Care Excellence (NICE) advises that falls and falls related injuries can be a common and serious problem for older people. They can be a major cause of disability. A falls protocol and policy was in place which stated that where people were assessed at high risk of falls, an additional falls care plan should be implemented. The provider was not consistently following their internal fall protocol and policy. For example, one person's falls risk assessment dated 9 October 2017 identified that they were at high risk of falls. This assessment considered factors such as their gender, age, falls history and cognition. However, a falls care plan had not been implemented. There was no specific plan of care on how to address their risk of falls. The individual's mobility care plan referenced that they were at high risk of falls and identified the need for them to wear appropriate footwear. However, there was no specific guidance on other measures which might be required to mitigate their risk of falls. A falls diary noted that their last fall was on the 9 October 2017 when they missed a chair and fell. One staff member told us, "We are finding that they tend to bump into items and miss chairs and fall due to deterioration in their eye sight." Staff had clearly identified a factor which increased the person's risk of falls, but this was not reflected within their care plan.

Specific aspects of falls management was safe and documentation reflected that staff were liaising with other healthcare professionals on how to manage the risk of falls. For example, referrals had been made to the falls prevention team, people's medicine had been reviewed and for some individuals, suitable assistive technology had been assessed and implemented. However, where falls care plans had been implemented, these were not consistently reviewed when an individual experienced a fall to ascertain if the measures implemented remained effective or whether other measures needed to be considered. One person had experienced 22 falls since May 2017, all of which had been un-witnessed. The falls care plan had identified the frequency of falls and recognised the times of day when the person was at highest risk. Guidance for staff to mitigate the risk of falls included 'requires close supervision during these times', however, there was no information on how this would be achieved. Staff members confirmed they were expected to keep an eye on the person, but no specific staff member was allocated to that task.

The above evidence demonstrates that robust systems were not consistently in place to assess, monitor and mitigate the risk of falls. This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Guidance produced by the Alzheimer's Society advises that, 'as people's dementia progresses, some people may develop behaviours that can be challenging.' Nursing staff advised that they worked in partnership with the mental health team, living well with dementia team and CPNs (community psychiatric nurses). Where people displayed behaviours which challenged, care plans identified how these behaviours presented. For example, one person's care plan identified that they could be anxious or aggressive at times. One staff member told us, "They can be aggressive but it's primarily during personal care and it usually means that they do not want our support any more." During the inspection, one person displayed behaviours which challenged and staff responded in a kind and sensitive manner, ensuring the dignity of the person whilst supporting them. Behavioural observation charts were in place for some people where staff recorded how they presented throughout the day. However, the findings from the behavioural charts did not consistently feed into the care plan and risk assessments. For example, there was no analysis of whether a person displayed behaviours that challenged at a specific time of the day or whether the current strategy to manage the behaviours remained efficient. We have identified this as an area of practice that needs improvement.

Systems were in place to assess staffing levels. The provider used their own dependency tool titled, 'electronic care needs assessment tool.' This electronic assessment tool considered people's nursing care needs, care needs and care banding. From this assessment, the tool then determined how many hours of care per week that were required to meet people's care needs. At the last inspection in June 2017, the provider was taking active steps to recruit additional staff and minimise the use of agency staff. Staff felt that staffing levels were a struggle at times and people and their relatives felt the high use of agency staff was having a negative impact. At this inspection in November 2017, additional staff had been recruited and although agency staff remained deployed, the use of agency staff had decreased compared to the last inspection in June 2017. Documentation reflected that agency staff were mostly required at night time and during the week commencing 20 October 2017, documentation identified that 11 nursing shifts were covered by agency staff and 13 care shifts were covered by agency staff.

Staff that we spoke with unanimously told us that they felt staffing levels were insufficient. One staff member told us, "There aren't enough staff most of the time. We work really hard to make sure the care doesn't suffer but we have no time to talk with the residents, except when we're helping them." Another staff member told us, "We're very busy. I've been told the number of staff is enough to care for people but that's not taking into account how much care some of these people need." A third staff member told us, "I feel very stressed and overworked. The care doesn't suffer because we work really hard, having said that, people do have to wait for things. We have to prioritise." The provider's electronic care needs assessment tool identified that between the months of August to October 2017, the total care hours per day had decreased due to lower occupancy. For example in August 2017, 41 people were living at the service and the total care hours per day were assessed as 165.6. In October 2017, 39 people were living at the service and total care hours per day were assessed as 159.9. Staff members told us that in their opinion although occupancy had decreased, people's level of dependency had increased and this was not reflected in the provider's dependency tool. We brought these concerns to the attention of the management team. People and their relatives had mixed opinions over staffing levels. One person told us, "Most days are fine but some days are a bit awkward and staff are rushing around." One relative told us, "Weekends are like a difference place here, there is a lot of agency staff who do not know residents names and Mum gets very anxious and aggressive with new people." Recent minutes from a staff meeting in October 2017 reflected staff concerns over staffing levels and the manager confirmed that following staff's feedback they would be reviewing people's level of dependency and review the dependency tool.

From our observations, we could see that staff were busy and working extremely hard. People's care needs were met and people's safety was not compromised. Staff were present within communal areas and at lunchtime, staff support was available in a timely manner to ensure that people's hydration and nutrition

needs were met. Steps were being taken following staff's feedback over staffing levels; however, we have identified this as an area of practice that needs improvement.

Staff had the knowledge and confidence to identify safeguarding concerns and were aware of their responsibilities in reporting any concerns. One staff member told us, "The (safeguarding) training is useful. It's good to have a reminder." Another staff member told us, "I would tell the manager if I thought another staff member was being abusive." Where safeguarding concerns had been raised, the management team worked in partnership with the local safeguarding team to ensure the safety of the person.

Thorough recruitment procedures were followed to check that staff were of suitable character to carry out their roles. Criminal checks had been made through the Disclosure and Barring Service (DBS) and staff had not started working at the service until it had been established that they were suitable. Staff members had provided proof of their identity and right to reside and to work in the United Kingdom prior to starting to work at the service. References had been taken up before staff were appointed and references were obtained from the most recent employer where possible. There was a system in place for checking and monitoring that nurses employed at the home had appropriate professional registration.

Risks associated with the safety of the environment and equipment were identified and managed appropriately. Regular fire alarm checks had been recorded, and staff knew what action to take in the event of a fire. Health and safety checks had been undertaken to ensure safe management of electrics, food hygiene, hazardous substances, moving and handling equipment, staff safety and welfare. There was a business continuity plan. This instructed staff on what to do in the event of the service not being able to function normally, such as a loss of power or evacuation of the property. In the event of the building needing to be evacuated, a place of safety had been nominated.

Oakhill House Care Home had safe systems for administration of medicines. All medicines were securely stored. Full records were maintained of medicines brought into Oakhill House Care Home, given to people and disposed of. All staff who supported people with their medicines did this carefully and did not rush people. They gave people the help they needed to take their medicines, including drinks of their choice. They checked each person had fully swallowed their medicine before signing that the person had taken their medicine. Where people were prescribed medicines on an 'as required' basis, there were clear protocols outlining the reasons a person needed their medicine and how often it was to be given in 24 hours. One person had recently been prescribed an anti-psychotic medicine on an 'as required' basis; however, there was no protocol in place. We brought this to the attention of a registered nurse who agreed to implement a protocol. Systems were in place to assess people's pain levels and ensure appropriate pain relief was provided to people when required.

At the last inspection in June 2017, we asked the provider to seek guidance from a national source about protected time when administering medicines. This was because nursing staff were regularly disrupted and disturbed when administering medicines by care staff. Improvements had been made and nursing staff now wore red tabards when administering medicines. A member of the management team told us, "Previously nurses were also carrying the phone around with them when administering medicines and this kept disrupting them. However, we have changed that practice." During the inspection, we spent time with nursing staff and observed that they were not disturbed when administering medicines and administered medicines in a calm and sensitive manner.

Before the inspection, the Care Quality Commission (CQC) received a number of notifications around medicine errors. At this inspection, we considered and reviewed how the provider made improvements when things had gone wrong. A member of the management team told us, "Following a medicine error, the

nurse involved attends supervision and complete a medication management competency which we then review together. Where a medicine error occurs with an agency nurse, we bring the error to the attention of the agency who supplied the nurse and they review the competency of the nurse. We also consider if we need to raise a safeguarding concern and seek advice from 111 or the person's GP about the medicine error." Following safety incidents, the provider completed a root cause analysis and worked in partnership with other professionals to discuss and review the incident and implement actions to drive improvement.

Arrangements were in place to ensure that the premises were kept clean and hygienic. The provider employed a dedicated team of housekeepers who worked seven days a week. One housekeeper told us, "We have a cleaning schedule in place that we follow and there is always plenty of PPE (personal protective equipment)." Infection control policies and procedures were readily available for staff to access alongside guidance on hand washing techniques. An infection control audit was completed on a regular basis and any actions identified were incorporated into the provider's home improvement plan (HIP).

Requires Improvement

Is the service well-led?

Our findings

Oakhill House Care Home was subject to a period of instability. The previous registered manager had recently left and the service was overseen by a regional management team. A newly appointed manager was now in post; however, the service was in the process of being taken over by a new provider. One staff member told us, "There has been uncertainty with the new owners taking over and I think that's affected some staff. The new manager has handled it quite well I think."

At our last inspection in June 2017, the provider was in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014. This was because accurate and complete documentation had not been maintained. In addition, systems to monitor risks and ensure compliance with the regulations had not been effective in all areas. An action plan had been submitted by the provider detailing how they would be meeting the legal requirements by October 2017. At this inspection, we found improvements had been made and the provider was meeting the requirements of the Health and Social Care Act 2008 (Regulated Activities) 2014. However, the provider's internal quality assurance framework required strengthening.

Each person had a range of documentation in place, these included topical medicines records. At the last inspection in June 2017, the provider's internal quality assurance framework had failed to identify concerns with the recording of topical medicines (topical creams). This was because the administration of topical creams was undertaken by care staff, however, staff dispensing the medicines failed to sign the Medication Administration Record (MAR chart). Improvements had been made and the provider had now implemented a 'topical medicine application record' which was kept in people's individual bedrooms. Documentation reflected that people were receiving their topical cream as required. However, guidance did not consistently reflect the frequency of application. For example, if the cream was to be applied once or twice a day. Staff were able to advise how frequently they were required to administer the cream but this was not reflected within documentation. We brought this to the attention of the management team.

There were systems to review the quality of service provided which included a variety of audits and checks. Audits are a quality improvement process that involves review of the effectiveness of practice against agreed standards. Audits help drive improvement and promote better outcomes for people who lived at the service. This Included weekly, monthly, quarterly and annual audits and reviews for safety, security and health care. The service was also supported by various professionals who worked for BUPA (the provider). Night visits had also been recently undertaken by the manager which considered the delivery of care at night. Following each individual audit, any actions or recommendations were added to Oakhill House Care Home 'home improvement plan' (HIP). However, despite systems in place to assess and monitor the quality of care, we found a number of shortfalls within care documentation which had not been identified. Internal quality assurance checks had also failed to identify that the provider was not consistently following their internal falls protocol and procedure.

Guidance produced by Skills for Care advises on the importance of promoting equality, diversity and human rights within the care planning process and decision making. Care plans considered people's religious and spiritual needs, however, there was no reference to people's sexual orientation. Documentation also

considered how people liked to express their sexuality. One person's care plan stated that wearing make-up was important to them. However, for a number of men, there was no information documented on how they wished to express their sexuality. For example, one person's care plan stated it was 'unknown.' However, staff were clearly able to tell us about this person and their background working in the public sector. One staff member told us, "They enjoy dressing smartly and that is important to them." This information was not reflected within their care plan. People's involvement within their care plan was not consistently evidenced. For example, there was no reference to whether people were involved in the design and formation of their care plan and whether they agreed with the contents of their care plan. Nearly everyone living at Oakhill House Care Home were living with dementia. Care plans considered whether people wanted to be involved in their care plan. However, where it was stated as 'yes', there was no subsequent information to demonstrate how that would happen. We brought these concerns to the attention of the management team who advised that staff hold care plan reviews with relatives but acknowledged further work was required to embed and promote people's equality and diversity within the care planning process.

Oakhill House Care Home was experiencing a turbulent period. The service was transitioning to a new provider. Steps had been taken to ease staff and relatives anxiety. A letter had been sent out to staff explaining what was happening and representatives from the new provider were due to meet with staff to discuss any concerns. A recent 'relative and resident' meeting had been held to discuss the changes with the provider and answer any queries. The management team were dedicated to easing any anxieties and supporting staff, people and relatives through the transition. However, the information provided about the transition was not consistently available or presented in a format for people living with dementia to understand. For example, no pictorial guides were available. We brought this feedback to the attention of the management team who were responsive to our concerns and agreed to take action.

A range of systems were in place to monitor compliance with the Health and Social Care Act 2008(Regulated Activities) 2014 and improvements had been made since the last inspection in June 2017. However, these systems were not always consistently effective in identifying shortfalls with documentation or whether information was provided in a format that enabled people living with dementia to understand. These shortfalls had no direct impact on the quality of care that people received. People received care that they required and the provider was responsive to our feedback. However, we have identified this as an area that requires improvement.

The management team and staff worked in partnership with key organisations to support care provision and service development. For example, where staff had noted a deterioration in a person's dementia they contacted the living well with dementia team and followed their advice and guidance. Links with the local community had been established. The manager told us, "We have a volunteer who visits regularly and spends time with people. We also have links with the local Church and the Vicar visits on a regular basis."

The management team was open and transparent. They consistently notified the Care Quality Commission of any significant events that affected people or the service. They were fully aware of updates in legislation that affected the service. The service's policies and operating procedures were appropriate for this type of service and were clearly summarised, to help staff when they needed to refer to them. They were reviewed on an on-going basis, were up to date with legislation and fully accessible to staff for guidance.

Staff successes were celebrated and the service had a dedicated staff walk of fame board. This included information on staff successes. For example in July 2017, a staff success poster was displayed congratulating two members of staff who had stepped up into management.

Systems were in place to gain feedback from people, staff and their relatives on the running of the service.

The provider deployed an external company to undertake satisfaction surveys. A member of the management team told us, "Satisfaction surveys have recently been sent out and we awaiting the findings for analysis."

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 will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who were at risk. Regulation 17 (2) (b).