Review of compliance

Oakhaven Residential Care Home Oakhaven Residential Care Home	
Region:	South West
Location address:	136-140 Hales Road Cheltenham Gloucestershire GL52 6TB
Type of service:	Care home service without nursing
Date of Publication:	January 2012
Overview of the service:	The home provides accommadation and care for up to twenty seven older people. The majority of the rooms have en suite facilities, there are two lounges and seperate dining room with an attractive rear garden. The home is well equipped to support the needs of older people including specialist bathing equipment.

Summary of our findings
for the essential standards of quality and safety

Our current overall judgement

Oakhaven Residential Care Home was not meeting one or more essential standards. Improvements are needed.

The summary below describes why we carried out this review, what we found and any action required.

Why we carried out this review

We carried out this review as part of our routine schedule of planned reviews.

How we carried out this review

We reviewed all the information we hold about this provider, carried out a visit on 6 December 2011, looked at records of people who use services, talked to staff and talked to people who use services.

What people told us

We spoke with seven people living in the home. They were all very positive about the quality of the care provided and the supportive and "friendly" staff.

Individuals made a number of comments to us about the care they receive and about living at Oakhaven Residential Care Home.

"This home is very nice and comfortable, they do their best to make it like home", "the food is gorgeous".

"The staff are all very friendly and kind", "good staff".

"Food and entertainment are the best things here".

"I give the home 100%".

We spoke with a relative who was very satisfied with the care that her relative received in the home. They told us: "staff are always approachable and keep me informed", "its very homely and they always make me feel welcome", "I would highly recommend this home".

Two district nurses we spoke with told us: "they are doing such good care", "we have a good relationship with the home", " we are very happy with the level of care".

What we found about the standards we reviewed and how well Oakhaven Residential Care Home was meeting them

Outcome 01: People should be treated with respect, involved in discussions about their care and treatment and able to influence how the service is run

People living in Oakhaven Residential Care Home have an opportunity to be involved in the arrangements made for their care needs to be met. People have their dignity and privacy respected.

Overall we found that Oakhaven Residential care Home is meeting this essential standard.

Outcome 04: People should get safe and appropriate care that meets their needs and supports their rights

The home undertakes comprehensive assessments of individual's care needs so that health and social care needs are identified.

We found that prescribed nutritional supplement is not always given as required potentially placing people's health and well being at risk.

Records of care and arrangements for providing care where individuals have specific needs such as maintaining skin integrity and responding to pressure sore care are not completed as required to evidence that the appropriate care is given.

Overall we found that Oakhaven Residential Care Home is not meeting this essential standard and we are taking compliance action.

Outcome 07: People should be protected from abuse and staff should respect their human rights

The home acted professionally in responding to concerns about possible abuse towards an individual living in the home.

Staff illustrated a good knowledge of Safeguarding and showed an understanding of their responsibility in relation to reporting any concerns about possible abuse.

We found that Oakhaven Residential Care Home is meeting this essential standard.

Outcome 14: Staff should be properly trained and supervised, and have the chance to develop and improve their skills

Staff are well supported to provide care to individuals living in the home. They receive the necessary training so that they have the required skills and knowledge to undertake their duties in a competent manner.

We found no direct evidence that the practice of the home not to employ dedicated domestic staff has a detrimental effect on the care provided. Staffing arrangements are at a level we would expect taking into account the varying, and for some complex, needs of individuals living in the home. The employment of dedicated domestic staff would provide greater opportunity for care staff to spend time with residents and focus on their primary role that of providing care.

Overall we found that Oakhaven Residential Care Home is meeting this essential standard.

Outcome 17: People should have their complaints listened to and acted on properly

People living in the home are able to voice their views and are aware of their right to make a formal complaint if they wish.

The home has an environment where individuals feel able to express any concerns, feel listened to and are confident that something would be done in response to any worries or concerns they may have.

Overall we found that Oakhaven Residential Care Home is meeting this essential standard.

Actions we have asked the service to take

We have asked the provider to send us a report within 28 days of them receiving this report, setting out the action they will take to improve. We will check to make sure that the improvements have been made.

Where we have concerns we have a range of enforcement powers we can use to protect the safety and welfare of people who use this service. When we propose to take enforcement action, our decision is open to challenge by a registered person through a variety of internal and external appeal processes. We will publish a further report on any action we have taken.

Other information

Please see previous reports for more information about previous reviews.

What we found for each essential standard of quality and safety we reviewed

The following pages detail our findings and our regulatory judgement for each essential standard and outcome that we reviewed, linked to specific regulated activities where appropriate.

We will have reached one of the following judgements for each essential standard.

Compliant means that people who use services are experiencing the outcomes relating to the essential standard.

A **minor concern** means that people who use services are safe but are not always experiencing the outcomes relating to this essential standard.

A **moderate concern** means that people who use services are safe but are not always experiencing the outcomes relating to this essential standard and there is an impact on their health and wellbeing because of this.

A **major concern** means that people who use services are not experiencing the outcomes relating to this essential standard and are not protected from unsafe or inappropriate care, treatment and support.

Where we identify compliance, no further action is taken. Where we have concerns, the most appropriate action is taken to ensure that the necessary improvements are made. Where there are a number of concerns, we may look at them together to decide the level of action to take.

More information about each of the outcomes can be found in the *Guidance about compliance: Essential standards of quality and safety*

Outcome 01:
Respecting and involving people who use services

What the outcome says

This is what people who use services should expect.

People who use services:
* Understand the care, treatment and support choices available to them.
* Can express their views, so far as they are able to do so, and are involved in making decisions about their care, treatment and support.
* Have their privacy, dignity and independence respected.
* Have their views and experiences taken into account in the way the service is provided and delivered.

What we found

Our judgement

The provider is compliant with Outcome 01: Respecting and involving people who use services

Our findings

What people who use the service experienced and told us
We asked people about the staff and they were very positive about how they were treated. One person told us: "they never talk down and are very respectful". Another person said: "we are always treated with respect".

People told us they were able to "tell staff about the help I need", "I was asked when I came here about the help I needed". One person told us: "if anything changes I just tell the staff and they will help me if I want the help".

One person told us they had been involved in reviewing their care plan. "I told them that I sometimes need more help on a bad day". We asked her if this always happened i.e. getting more help when they needed it: "o yes I only have to say and staff will help me".

The home has regular Resident's meetings. One person told us they had made suggestions about changes to the menu and these had been acted on. Another person said the meetings were very helpful in talking about "what we think and want to happen", "its a chance for us to say if we want something different or not happy with something".

Other evidence

We observed staff supporting and assisting individuals in a sensitive and respectful manner. During the mealtime staff were seen helping an individual with their meal and they did this in an appropriate way. During the meal staff generally were available to help if this was required.

Our judgement
People living in Oakhaven Residential Care Home have an opportunity to be involved in the arrangements made for their care needs to be met. People have their dignity and privacy respected.

Overall we found that Oakhaven Residential care Home is meeting this essential standard.

Outcome 04:
Care and welfare of people who use services

What the outcome says

This is what people who use services should expect.

People who use services:
* Experience effective, safe and appropriate care, treatment and support that meets their needs and protects their rights.

What we found

Our judgement

There are minor concerns with Outcome 04: Care and welfare of people who use services

Our findings

What people who use the service experienced and told us
People we spoke with told us that they felt their care needs were being met. One person said: "I only have to speak to staff about having help and they will always be there when I need them.". Another person said: "when I came here I was asked about the care I needed. I always get the care when I want it. They give it (care) straight away".

People told us: "staff are all very kind", "staff are very helpful and kind".

We asked one person about the activities in the home and they said; "there is always something going on every day".

Other evidence
We looked at care plans for three individuals. They were comprehensive and detailed. Included were risk assessments around falling and behaviour. Mobility assessments had been carried out with information about needs for equipment and moving and handling arrangements. Nutrition assessments had been completed. There was information about the individual personal circumstances and social needs. We were told the home is to introduce personalised dairies which will provide more personal information about the individuals in the home.

One person with dementia had a detailed care plan about how this effected their behaviour and approach staff were to take when dealing with this behaviour.

For one person we looked at there was a "Departure Alert". This was about the individual leaving the home and placing themselves at risk. The term "wandering" was used. The person had consented to the use of an alarm pendant to reduce the risk and alert staff to when they might leave the home. We later spoke to this individual and they told us they were happy to wear the alarm: "its so I am safe" they told us.

Reviews of care plans are held regularly and we noted that review records had been signed by the individual.

We looked at the medication records for two individuals. Both had been prescribed nutritional supplements daily. The record for one individual recorded only nine occasions over a period of four weeks as having been given. For the other person the record showed only to have been given on two occasions and the stock recorded against that held did not agree.

We spoke with two district nurses about the care provided in the home. This was specifically about two individuals they visit who currently have pressure sores. One told us they were "very happy with the level of care". That staff have received training in supporting individuals who need skin care and follow the guidance given and are "very good at alerting us to any problem". They said that the home was "progressing and take advice on board". We looked at the records of care specifically turning charts and these had been completed though there was some inconsistencies with the recording of turning times. The times did not always correspond to the period requested namely hourly. We confirmed with the nurses that they had no concerns about the quality of care and they believed the condition of the two individuals was improving as expected.

Our judgement
The home undertakes comprehensive assessments of individual's care needs so that health and social care needs are identified.

We found that prescribed nutritional supplement is not always given as required potentially placing people's health and well being at risk.

Records of care and arrangements for providing care where individuals have specific needs such as maintaining skin integrity and responding to pressure sore care are not completed as required to evidence that the appropriate care is given.

Overall we found that Oakhaven Residential Care Home is not meeting this essential standard and we are taking compliance action.

Outcome 07:
Safeguarding people who use services from abuse

What the outcome says

This is what people who use services should expect.

People who use services:
* Are protected from abuse, or the risk of abuse, and their human rights are respected and upheld.

What we found

Our judgement

The provider is compliant with Outcome 07: Safeguarding people who use services from abuse

Our findings

What people who use the service experienced and told us
People we spoke with told us they felt safe in the home. They said that staff always treated them as they would want. One person told us: "staff always treat me in nice way never say anything that makes me feel upset". We asked this person whether they had ever seen staff behave in a way which was disrespectful or spoken in a harsh, unkind way. They said: "no never, staff would never behave in that way."

We asked another person what they would do if they were spoken in a disrespectful way or were made to do something they didn't want to do. They told us: "that has never happened, what I do is always up to me, its my choice. If it did happen I would tell the matron she would do something about it I am sure".

Other evidence
We spoke with four members of staff. We asked them about their understanding of abuse. They were able to give us good examples of what constitutes abuse in a care home: "forcing people to do things they do not want to do," not giving people choice", "ignoring someone when they need help". They told us that if they had any concerns about possible abuse they would report it to the matron or manager. When asked if they were not satisfied with the response to their concerns they said they would "go to social services". They were aware of the whistle blowing policy and that this gave them the right to "go outside the home if we wanted to".

All of those staff we spoke with had completed Safeguarding Adults training.

The home had responded to an incident of possible abuse by an individual living in the home towards another resident by reporting the concern to the local safeguarding team and ourselves. The matter was under investigation however the home had taken steps to reduce the risks associated with an individual's behaviour.

Our judgement
The home acted professionally in responding to concerns about possible abuse towards an individual living in the home.

Staff illustrated a good knowledge of Safeguarding and showed an understanding of their responsibility in relation to reporting any concerns about possible abuse.

We found that Oakhaven Residential Care Home is meeting this essential standard.

Outcome 14:
Supporting staff

What the outcome says

This is what people who use services should expect.

People who use services:
* Are safe and their health and welfare needs are met by competent staff.

What we found

Our judgement

The provider is compliant with Outcome 14: Supporting staff

Our findings

What people who use the service experienced and told us
We did not speak to individuals living in the home about this essential standard.

Other evidence
All of the four staff members we spoke with told us they felt well supported by the management and senior staff. Opportunities are provided to discuss any concerns or issues through regular staff meeting and one to one supervision. One staff member said : "we can talk about anything we want".

We asked about the training provided and all told us they had completed "mandatory" training namely moving and handling, infection control, health & safety and food hygiene.

An area raised by all of the staff we spoke with was that of the home not employing dedicated domestic staff. All of the domestic duties are carried out by care staff and we were told by the owner of the home this is very clearly part of their role. Staff made a number of comments to us about this arrangement: "some days do not have time to do all of the cleaning", "be lovely if we did have domestic staff", "if we didn't have to do domestic tasks things would be better for residents" (this was about being able to spend more time with residents). One staff member when asked about activities said "its difficult at times because there is cleaning that must be done" and another said, "feel like we want to do things with the residents but there is all the cleaning" and "feels like we are rushing at times puts us under pressure". We asked people living in the home about the cleanliness and all of those we spoke were very positive about the cleanliness of the home which we observed at the time of our visit. One person told us

"everything is always so clean".

Our judgement
Staff are well supported to provide care to individuals living in the home. They receive the necessary training so that they have the required skills and knowledge to undertake their duties in a competent manner.

We found no direct evidence that the practice of the home not to employ dedicated domestic staff has a detrimental effect on the care provided. Staffing arrangements are at a level we would expect taking into account the varying, and for some complex, needs of individuals living in the home. The employment of dedicated domestic staff would provide greater opportunity for care staff to spend time with residents and focus on their primary role that of providing care.

Overall we found that Oakhaven Residential Care Home is meeting this essential standard.

Outcome 17:
Complaints

What the outcome says

This is what people should expect.

People who use services or others acting on their behalf:
* Are sure that their comments and complaints are listened to and acted on effectively.
* Know that they will not be discriminated against for making a complaint.

What we found

Our judgement

The provider is compliant with Outcome 17: Complaints

Our findings

What people who use the service experienced and told us
We asked people about making complaints. One person told us they knew they could make a complaint if they needed to "but have never had to". Another person told us they had spoken to the matron and "something was done about it".

One person said they felt staff listened to what they had to say. They told us that they had made suggestions at a residents meeting about meals and they had been carried out.
Another person said they had never made a complaint "but know I can I would go to the owner".

We noted that a copy of the complaints procedure was displayed on the home's notice board.

Other evidence
We are currently responding to an issue raised by a relative. We have discussed this with the owner who has acted positively to our involvement. We have raised with the owner how communication could have been better with regard to the matter concerned.

Our judgement
People living in the home are able to voice their views and are aware of their right to make a formal complaint if they wish.

The home has an environment where individuals feel able to express any concerns,

feel listened to and are confident that something would be done in response to any worries or concerns they may have.

Overall we found that Oakhaven Residential Care Home is meeting this essential standard.

Action
we have asked the provider to take

Compliance actions

The table below shows the essential standards of quality and safety that **are not being met**. Action must be taken to achieve compliance.

Regulated activity	Regulation	Outcome
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 04: Care and welfare of people who use services
	How the regulation is not being met: We found evidence that prescribed nutritional supplement is not always given as required potentially placing people's health and well being at risk. Records of care and arrangements for providing care where individuals have specific needs such as maintaining skin integrity and responding to pressure sore care are not completed as required to evidence that the appropriate and consistent care is given.	

The provider must send CQC a report that says what action they are going to take to achieve compliance with these essential standards.

This report is requested under regulation 10(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The provider's report should be sent to us within 28 days of the date that the final review of compliance report is sent to them.

Where a provider has already sent us a report about any of the above compliance actions, they do not need to include them in any new report sent to us after this review of compliance.

CQC should be informed in writing when these compliance actions are complete.

What is a review of compliance?

By law, providers of certain adult social care and health care services have a legal responsibility to make sure they are meeting essential standards of quality and safety. These are the standards everyone should be able to expect when they receive care.

The Care Quality Commission (CQC) has written guidance about what people who use services should experience when providers are meeting essential standards, called *Guidance about compliance: Essential standards of quality and safety*.

CQC licenses services if they meet essential standards and will constantly monitor whether they continue to do so. We formally review services when we receive information that is of concern and as a result decide we need to check whether a service is still meeting one or more of the essential standards. We also formally review them at least every two years to check whether a service is meeting all of the essential standards in each of their locations. Our reviews include checking all available information and intelligence we hold about a provider. We may seek further information by contacting people who use services, public representative groups and organisations such as other regulators. We may also ask for further information from the provider and carry out a visit with direct observations of care.

When making our judgements about whether services are meeting essential standards, we decide whether we need to take further regulatory action. This might include discussions with the provider about how they could improve. We only use this approach where issues can be resolved quickly, easily and where there is no immediate risk of serious harm to people.

Where we have concerns that providers are not meeting essential standards, or where we judge that they are not going to keep meeting them, we may also set improvement actions or compliance actions, or take enforcement action:

Improvement actions: These are actions a provider should take so that they **maintain** continuous compliance with essential standards. Where a provider is complying with essential standards, but we are concerned that they will not be able to maintain this, we ask them to send us a report describing the improvements they will make to enable them to do so.

Compliance actions: These are actions a provider must take so that they **achieve** compliance with the essential standards. Where a provider is not meeting the essential standards but people are not at immediate risk of serious harm, we ask them to send us a report that says what they will do to make sure they comply. We monitor the implementation of action plans in these reports and, if necessary, take further action to make sure that essential standards are met.

Enforcement action: These are actions we take using the criminal and/or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers are set out in the law and mean that we can take swift, targeted action where services are failing people.

Information for the reader

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