Inspection Report

We are the regulator: *Our job is to check whether hospitals, care homes and care services are meeting essential standards.*

Oak View Residential Care Home

47-49 Beach Road, Hayling Island, PO11 0JB

Tel: 02392465473

Date of Inspection: 15 January 2013

Date of Publication: February 2013

We inspected the following standards as part of a routine inspection. This is what we found:

Consent to care and treatment	✖ Action needed
Care and welfare of people who use services	✖ Action needed
Safeguarding people who use services from abuse	✔ Met this standard
Requirements relating to workers	✖ Action needed
Assessing and monitoring the quality of service provision	✖ Action needed

Details about this location

Registered Provider	Stephen Geach
Registered Manager	Mrs. Rachel Adey
Overview of the service	Oak View is a 34 bedded care home for older people who may have dementia. It is situated on Haying Island near the sea front. It has many ensuite rooms and some double rooms.
Type of service	Care home service without nursing
Regulated activity	Accommodation for persons who require nursing or personal care

Contents

When you read this report, you may find it useful to read the sections towards the back called 'About CQC inspections' and 'How we define our judgements'.

Summary of this inspection

Why we carried out this inspection

This was a routine inspection to check that essential standards of quality and safety referred to on the front page were being met. We sometimes describe this as a scheduled inspection.

This was an unannounced inspection.

How we carried out this inspection

We carried out a visit on 15 January 2013, checked how people were cared for at each stage of their treatment and care, talked with people who use the service and talked with carers and / or family members. We talked with staff.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

What people told us and what we found

Oak View is a home for older people and they are registered for up to 34 people. On the day we inspected there were 34 people living at the home the majority of whom had memory impairment. During our inspection we spoke with four staff, the manager, the provider, a relative and three people who use the service.

As not everyone who lived at Oak View was able to tell us what they thought about the care and support provided, we used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us. We spent time in their company in the lounge and dining area observing the support people received before and during their lunch?. We saw that the staff were friendly and respectful and that they were quick to respond if anyone appeared unhappy or distressed.

A relative told us, "I can not find fault" and "If I did not trust the staff then I would not leave my mother here". People told us that " Staff are nice and very hardworking".

Staff we met on the day told us about the training they had attended recently and that they were able to speak openly with the manager and provider about any concerns.

Whilst our observations, people using the service, relatives and staff were positive about the care provided at the home, we found that the care plans and other records did not reflect the needs of people and the support they needed.

You can see our judgements on the front page of this report.

What we have told the provider to do

We have asked the provider to send us a report by 15 February 2013, setting out the action they will take to meet the standards. We will check to make sure that this action is taken.

Where providers are not meeting essential standards, we have a range of enforcement powers we can use to protect the health, safety and welfare of people who use this service (and others, where appropriate). When we propose to take enforcement action, our decision is open to challenge by the provider through a variety of internal and external appeal processes. We will publish a further report on any action we take.

More information about the provider

Please see our website www.cqc.org.uk for more information, including our most recent judgements against the essential standards. You can contact us using the telephone number on the back of the report if you have additional questions.

There is a glossary at the back of this report which has definitions for words and phrases we use in the report.

Our judgements for each standard inspected

Consent to care and treatment ✖ Action needed

Before people are given any examination, care, treatment or support, they should be asked if they agree to it

Our judgement

The provider was not meeting this standard.

Before people received any care or treatment they were asked for their consent and the provider acted in accordance with their wishes. However the majority of people had not been assessed regarding their capacity which left them at risk of not being involved in their care.

We have judged that this has a minor impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

Reasons for our judgement

The majority of people living at Oak View at the time of our inspection had dementia and could not always express what they wanted or needed. Those that were able understood the care and treatment choices available to them. We saw members of staff were patient and respectful with people who used the service. We observed them approach and explain to people the care that was going to be provided.

Conversations we had with staff illustrated that they were very keen to ensure that people's choices were promoted and that they involved them in their life choices at the home. We observed staff asking individuals who looked puzzled or confused what they needed and talking to them before assisting them. For example we observed staff gently speaking with a person about lunch and encouraging them to feed themselves. We observed staff taking their time when assisting people and enabling them to be as independent as possible.

We found that people's preferences and wishes were taken into account in their day to day care for example people chose where they ate their meals.

The staff told us that each individual had a care plan and that they were aware of the support individuals needed but that they also asked them, as people changed their minds, or they asked again later.

We saw that several people had safety helmets on, the manager told us that this was because they had had falls or had been assessed as being at risk of falls. She told us that these people also wore hip protectors. We looked at the care plans for the five people living at the home which included one person who was wearing the safety helmet. We did not see any assessments of capacity and what people were able to make decisions about,

for example care and treatment. The manager showed us an example of an assessment and two additional care plans where capacity assessments had been carried out. They said they had not completed assessments on everyone living in the home. The assessments that had been completed had not been reviewed since and there was no plan of care based on the assessments. This meant that people's rights and ability to consent had not been assessed.

Care and welfare of people who use services ✖ Action needed

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

Our judgement

The provider was not meeting this standard.

People were at risk of not always receiving the care, treatment and support that met their needs and protected their rights as the instructions for the support staff should give were not clear or omitted. Care plans had not been reviewed regularly or consistently.

We have judged that this has a moderate impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

Reasons for our judgement

When we spoke with people using the service they told us staff gave them the help and support they needed. A visitor told us that they felt confident in the staff and that their relative was well cared for. Staff told us they would support people in the way they liked and encouraged them to do as much for themselves as possible. Our observations confirmed people had their own individual routines which were respected. The atmosphere was relaxed with people interacting well with each other and with staff.

We looked at the care files for five people living at the home. On one care file we saw that there was information from the dietician regarding food supplements as there had been concern about the person's weight loss. The care plan made no reference to these supplements although a comment on 29 June 2012 on the review sheet stated "eating better weight up". The manager told us that the supplements were no longer needed. The nutritional screening tool for this person was completed monthly until July 2012 with action for staff "to monitor and record". Staff had recorded the person's weight between July and November 2012 with the exception of October. They had not evaluated this information even though their weight had fluctuated.

Four of the care plans we looked at had generally been reviewed monthly until November 2012. However there were exceptions on each of the files we looked at for example, for two people where there had been concerns about their health the care plan regarding their skin integrity was last reviewed in July 2012. For another person their care plan regarding malnutrition and dehydration had last been reviewed in July 2012.

All the care plans had an assessment called "Pre admission and assessment form". They were assessments of people's overall needs and linked to the care plans so staff could see if needs had changed or new ones had been identified. One of the instructions stated "To be completed at intervals of three months or less". We asked the manager how often she expected them to be done and she told us "monthly". On four of the five care plans we saw that these assessments had last been done in July 2012.

On walking round the home we saw that for one person their bed did not have a mattress and a ripple mattress to help prevent pressure areas was on the base of the bed. We asked the manger about this and were told that the person was at risk of falls out of the bed, and in addition at night mattresses were placed on the floor. Although the staff had completed a risk assessment there was no assessment of why this action was deemed to be the best and it did not link to the care plans for mobility, sleeping or falls. The care plans also made no reference on the use of the ripple mattress, for example, that staff should monitor the person's weight and adjust the mattress accordingly.

Other risks to people had been identified through an assessment and there was action for staff to take to lessen those risks for example a person was at risk of falls wore hip protectors and a padded head gear. There was no assessment of how they involved people in the decision making process for example the person using the service or others, if they did not have capacity. For one person their mobility care plan had not been reviewed since September 2012 and their moving and handling care plan since July 2012. For another person their risk assessment for falls had not been reviewed since July 2012.

On another care plan we saw that the person was prone to urinary infections the action for staff to take to help prevent this did not match the need; it talked about encouraging the person to participate in activities.

We also saw other conflicting information for staff. On one care plan it stated to ensure the person's skin integrity, "drink plenty of fluid". However their care plan for eating and drinking said "staff to limit drink as they will drink one after another and it will affect their diabetes". This means the person was at risk of not receiving the correct support for their needs.

Safeguarding people who use services from abuse ✓ Met this standard

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

Our judgement

The provider was meeting this standard.

People who use the service were protected from the risk of abuse, because the provider had taken reasonable steps to identify the possibility of abuse and prevent abuse from happening.

Reasons for our judgement

We spoke to a relative, who told us that they felt their family member was safe and well cared for at the home and that because of the professionalism of the staff they trusted them. We saw evidence that people were not distressed by the care and support being provided by staff at the home. People living at the home did not express or demonstrate any anxieties when interacting with staff members.

We found that people who use the service were protected from the risk of abuse, because the provider had taken reasonable steps to identify the possibility of abuse and prevent abuse from happening. We spoke with three of the care staff on duty at the time of our inspection. They demonstrated a good understanding about types of abuse, how to recognise if abuse might be occurring and the action they should take if they suspected anybody living at the home was being subject to abuse.

Staff we spoke with demonstrated an awareness of the Mental Capacity Act. They knew that people should be allowed to make their own decisions. But they also knew that some times people's illnesses meant that did not have the capacity to make certain decisions and that in these cases procedures would have to be followed to ensure that any decisions made for the person were in their best interests. However there were no records of the assessment of people's capacity or any decisions made in their best interest.

The manager said that they did not hold people's personal money at the home and this was kept at headquarters and invoices were raised when services such as hairdressing had been purchased. They did however hold cash for one person who was assisted to go into the community several times a week. The cash was double checked and signed for by staff and the person who was assisting the person and any remaining money and invoices were given to staff when the person returned to the home.

Requirements relating to workers ✖ Action needed

People should be cared for by staff who are properly qualified and able to do their job

Our judgement

The provider was not meeting this standard.

People were at risk of receiving care from staff who may not have been suitable as the recruitment and the induction processes were not robust.

We have judged that this has a minor impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

Reasons for our judgement

We looked at the recruitment files of three recently recruited members of staff. There was evidence that the necessary checks had been undertaken, for example; application form, interviews, Enhanced Criminal Record Bureau checks, two references and identity verification. However, we saw that for one member of staff a reference was from someone who had not seen them for two years. For another member of staff they had worked at the home previously but had left and staff from the home had given them references. Of the six references we saw only one was dated so it was not possible to clarify that they had been received before the member of staff had commenced work. We found that the process for recruiting staff did not fully protect people using the service safe.

We saw evidence of an induction period based on the Skills for Care Induction. However one member of staff who had commenced employment at the end of 2011 had not yet completed their induction. Senior staff said that there had been some issues which had since been resolved. The manager told us that they would ensure that the person completed their induction booklet and look at the system around this.

We saw certificates of essential training for new staff, such as first aid, medicines management and moving and handling. Staff told us about the training they had received and their experiences as new members of staff. Staff were positive about their experiences and said that senior staff were approachable. "Things are really organised and proactive". We have a "good team that are helpful and supportive". Our observations of staff and our conversations with them, demonstrated that staff were aware of people's needs, how to communicate with people and offer them choices. The staff worked well as a team talking with each other to ensure that people's needs were met.

Assessing and monitoring the quality of service provision ✖ Action needed

The service should have quality checking systems to manage risks and assure the health, welfare and safety of people who receive care

Our judgement

The provider was not meeting this standard.

The provider did not have an effective system to regularly assess and monitor the quality of service that people receive placing people at risk of not receiving the support and care they needed.

We have judged that this has a minor impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

Reasons for our judgement

People who use the service, their representatives and staff were asked for their views about their care and treatment and they were acted on. A relative told us that they were involved in reviews of care and were able to ask questions or share their concerns with the manager or staff at the home.

We saw that the surveys from relatives had been evaluated and that the results were available on the notice boards. The report included any action that had been taken and enabled people using the service and/or visitors to make further comment.

The manager shared with us a report dated October 2012 of an audit carried out by the consultant the home uses to assist them in monitoring the service. They looked at a few areas every two or three months and the manager has an action plan based on the issues that arise from this.

The manager showed us an example of the areas they monitored for example the cleanliness of the home. They had delegated other issues such as care plan reviews to senior staff, the provider however, did not formally audit the whole service to ensure that it was meeting people's needs and was safe. Two examples of this were recruitment and the care plans which had not been consistently reviewed and in some cases gave staff conflicting information.

This section is primarily information for the provider

Action we have told the provider to take

Compliance actions

The table below shows the essential standards of quality and safety that **were not being met**. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	**Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010** **Consent to care and treatment**
	How the regulation was not being met: Assessment of people's capacity had not been carried out for all the people living at the service. This means that their rights may not have been respected and that they were at risk of not having their wishes and needs met. Health and Social Care Act 2008 Regulation 18
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	**Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010** **Care and welfare of people who use services**
	How the regulation was not being met: Care plans had not been reviewed regularly and consistently and where needs had changed they did not reflect these changes. Some care plans did not give staff the correct or consistent information in order that they could support people. Health and Social Care Act 2008 Regulation 9 1(a) (b)(i)(ii)
Regulated activity	Regulation

This section is primarily information for the provider

Accommodation for persons who require nursing or personal care	**Regulation 21 HSCA 2008 (Regulated Activities) Regulations 2010** **Requirements relating to workers**
	How the regulation was not being met: The provider could not show that the references had been received before the member of staff had commenced employment. The provider did not have a process to ensure that induction was completed and that staff were suitably qualified to support people at Oak View. Health and Social Care Act 2008 Regulation 21 (a)(i)(ii)(b)
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	**Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010** **Assessing and monitoring the quality of service provision**
	How the regulation was not being met: The lack of consistent monitoring of the service means that there are areas such as care plans which were not up to date and give conflicting information to staff.and recruitment which placed people at risk. Health and Social Care Act 2008 Regulation 10 (1)(a)(b) 2(iii) (c)(i)

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 by 15 February 2013.

CQC should be informed when compliance actions are complete.

We will check to make sure that action has been taken to meet the standards and will report on our judgements.

About CQC inspections

We are the regulator of health and social care in England.

All providers of regulated health and social 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 essential standards are described in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. We regulate against these standards, which we sometimes describe as "government standards".

We carry out unannounced inspections of all care homes, acute hospitals and domiciliary care services in England at least once a year to judge whether or not the essential standards are being met. We carry out inspections of dentists and other services at least once every two years. All of our inspections are unannounced unless there is a good reason to let the provider know we are coming.

There are 16 essential standards that relate most directly to the quality and safety of care and these are grouped into five key areas. When we inspect we could check all or part of any of the 16 standards at any time depending on the individual circumstances of the service. Because of this we often check different standards at different times but we always inspect at least one standard from each of the five key areas every year. We may check fewer key areas in the case of dentists and some other services.

When we inspect, we always visit and we do things like observe how people are cared for, and we talk to people who use the service, to their carers and to staff. We also review information we have gathered about the provider, check the service's records and check whether the right systems and processes are in place.

We focus on whether or not the provider is meeting the standards and we are guided by whether people are experiencing the outcomes they should be able to expect when the standards are being met. By outcomes we mean the impact care has on the health, safety and welfare of people who use the service, and the experience they have whilst receiving it.

Our inspectors judge if any action is required by the provider of the service to improve the standard of care being provided. Where providers are non-compliant with the regulations, we take enforcement action against them. If we require a service to take action, or if we take enforcement action, we re-inspect it before its next routine inspection was due. This could mean we re-inspect a service several times in one year. We also might decide to re-inspect a service if new concerns emerge about it before the next routine inspection.

In between inspections we continually monitor information we have about providers. The information comes from the public, the provider, other organisations, and from care workers.

You can tell us about your experience of this provider on our website.

How we define our judgements

The following pages show our findings and regulatory judgement for each essential standard or part of the standard that we inspected. Our judgements are based on the ongoing review and analysis of the information gathered by CQC about this provider and the evidence collected during this inspection.

We reach one of the following judgements for each essential standard inspected.

✓ **Met this standard**	This means that the standard was being met in that the provider was compliant with the regulation. If we find that standards were met, we take no regulatory action but we may make comments that may be useful to the provider and to the public about minor improvements that could be made.
✖ **Action needed**	This means that the standard was not being met in that the provider was non-compliant with the regulation. We may have set a compliance action requiring the provider to produce a report setting out how and by when changes will be made to make sure they comply with the standard. We monitor the implementation of action plans in these reports and, if necessary, take further action. We may have identified a breach of a regulation which is more serious, and we will make sure action is taken. We will report on this when it is complete.
✖ **Enforcement action taken**	If the breach of the regulation was more serious, or there have been several or continual breaches, we have a range of actions we take using the criminal and/or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers include issuing a warning notice; restricting or suspending the services a provider can offer, or the number of people it can care for; issuing fines and formal cautions; in extreme cases, cancelling a provider or managers registration or prosecuting a manager or provider. These enforcement powers are set out in law and mean that we can take swift, targeted action where services are failing people.

How we define our judgements (continued)

Where we find non-compliance with a regulation (or part of a regulation), we state which part of the regulation has been breached. We make a judgement about the level of impact on people who use the service (and others, if appropriate to the regulation) from the breach. This could be a minor, moderate or major impact.

Minor impact – people who use the service experienced poor care that had an impact on their health, safety or welfare or there was a risk of this happening. The impact was not significant and the matter could be managed or resolved quickly.

Moderate impact – people who use the service experienced poor care that had a significant effect on their health, safety or welfare or there was a risk of this happening. The matter may need to be resolved quickly.

Major impact – people who use the service experienced poor care that had a serious current or long term impact on their health, safety and welfare, or there was a risk of this happening. The matter needs to be resolved quickly

We decide the most appropriate action to take to ensure that the necessary changes are made. We always follow up to check whether action has been taken to meet the standards.

Glossary of terms we use in this report

Essential standard

The essential standards of quality and safety are described in our *Guidance about compliance: Essential standards of quality and safety*. They consist of a significant number of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. These regulations describe the essential standards of quality and safety that people who use health and adult social care services have a right to expect. A full list of the standards can be found within the *Guidance about compliance*. The 16 essential standards are:

Respecting and involving people who use services - Outcome 1 (Regulation 17)
Consent to care and treatment - Outcome 2 (Regulation 18)
Care and welfare of people who use services - Outcome 4 (Regulation 9)
Meeting Nutritional Needs - Outcome 5 (Regulation 14)
Cooperating with other providers - Outcome 6 (Regulation 24)
Safeguarding people who use services from abuse - Outcome 7 (Regulation 11)
Cleanliness and infection control - Outcome 8 (Regulation 12)
Management of medicines - Outcome 9 (Regulation 13)
Safety and suitability of premises - Outcome 10 (Regulation 15)
Safety, availability and suitability of equipment - Outcome 11 (Regulation 16)
Requirements relating to workers - Outcome 12 (Regulation 21)
Staffing - Outcome 13 (Regulation 22)
Supporting Staff - Outcome 14 (Regulation 23)
Assessing and monitoring the quality of service provision - Outcome 16 (Regulation 10)
Complaints - Outcome 17 (Regulation 19)
Records - Outcome 21 (Regulation 20)

Regulated activity

These are prescribed activities related to care and treatment that require registration with CQC. These are set out in legislation, and reflect the services provided.

Glossary of terms we use in this report (continued)

(Registered) Provider

There are several legal terms relating to the providers of services. These include registered person, service provider and registered manager. The term 'provider' means anyone with a legal responsibility for ensuring that the requirements of the law are carried out. On our website we often refer to providers as a 'service'.

Regulations

We regulate against the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009.

Responsive inspection

This is carried out at any time in relation to identified concerns.

Routine inspection

This is planned and could occur at any time. We sometimes describe this as a scheduled inspection.

Themed inspection

This is targeted to look at specific standards, sectors or types of care.

Contact us

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