Review of compliance

Laudcare Limited Oaktree Care Home	
Region:	South West
Location address:	Lark Rise Brimsham Park, Yate Bristol BS37 7PJ
Type of service:	Care home service without nursing Care home service with nursing
Date of Publication:	December 2011
Overview of the service:	Oaktree Care Home is a nursing and residential home in Yate providing residential care, nursing care and respite care for up to 80 people including those with dementia and requiring palliative care.

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

Our current overall judgement

Oaktree 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 because concerns were identified in relation to:

Outcome 09 - Management of medicines
Outcome 13 - Staffing

How we carried out this review

We reviewed all the information we hold about this provider, carried out a visit on 14 November 2011, carried out a visit on 21 November 2011, checked the provider's records, observed how people were being cared for, talked to staff and talked to people who use services.

What people told us

We reviewed the service as a result of concerns which had been raised with South Gloucestershire Council through the safeguarding team. The concerns raised focused on the dementia care floor of the home.

We saw evidence of good team work and a supportive environment. The staff that we spoke with all said that they had not experienced any bullying within their work environment and that they felt supported by the current peripatetic manager.

There were practical signs of minimal staffing levels on duty both during the day and at night. We observed some gaps in record keeping and staff told us that they had been short staffed on the day of our visit. They told us they had not really had time to take breaks. We saw that although there were enough staff rostered on to work each shift within the home as a whole the numbers of staff rostered on each floor did not reflect the staffing ratios expected for the number of residents within the home.

Staff we spoke with demonstrated a good understanding of the people's needs but appeared under pressure to fulfil care tasks due to minimal staffing levels. Despite minimal staffing levels we observed both day and night staff treating people with dignity and respect. We saw staff talking to people in a calm and clear manner and going at people's pace.

No-one living in the home was able to look after their own medicines at the time of our inspection. All medicines are looked after and given by staff. We saw staff giving people their morning medicines in a safe and respectful way.

We saw that one person had not wanted to take their medicines when they were first offered. The nurse returned later to offer them again. When they were again not wanted nursing staff safely disposed of the medicines. We saw another person was not awake at the time of the medicine round and that although staff tried to wake the person they were not able to take their medicines at that time. The nurse returned later to administer their medicines.

We observed that people are given medicines in a caring and sensitive way. Medicines were put into a plastic medicine cup and people were supported to take their medicines in a manner that they wished. We saw that nursing staff put each tablet (or capsule) onto a spoon in order that people could take their medicines one at a time.

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

Outcome 09: People should be given the medicines they need when they need them, and in a safe way

The service does not fully protect people against the risks associated with the unsafe use and management of medicines by means of the making of appropriate arrangements for the recording and safe administration of medicines. Records for the use of creams and ointments do not demonstrated that people have received these medicines as prescribed for them. Advice for the safe administration of some medicines had not been followed, this could cause people harm.

Outcome 13: There should be enough members of staff to keep people safe and meet their health and welfare needs

People who use the service cannot be confident that the basis for deciding sufficient staffing levels has been determined through the analysis of their combined needs and risk assessments. This means that people cannot be confident that there are suitable numbers of staff in place to support their needs. However, staff on duty have suitable knowledge about the people they are caring for and treat them with respect.

Actions we have asked the service to take

We have asked the provider to send us a report within 7 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

In a previous review, we suggested that some improvements were made for the following essential standards:

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

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

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 09:
Management of medicines

What the outcome says

This is what people who use services should expect.

People who use services:
* Will have their medicines at the times they need them, and in a safe way.
* Wherever possible will have information about the medicine being prescribed made available to them or others acting on their behalf.

What we found

Our judgement

There are moderate concerns with Outcome 09: Management of medicines

Our findings

What people who use the service experienced and told us
No-one living in the home was able to look after their own medicines at the time of our inspection. All medicines are looked after and given by staff. We saw staff giving people their morning medicines in a safe and respectful way.

We saw that one person had not wanted to take their medicines when they were first offered. The nurse returned later to offer them again. When they were not wanted again nursing staff safely disposed of the medicines. We saw another person was not awake at the time of the medicine round and that although staff tried to wake the person they were not able to take their medicines at that time. The nurse returned later to administer their medicines.

We observed that people are given medicines in a caring and sensitive way. Medicines were put into a plastic medicine cup and people were supported to take their medicines in a manner that they wished. We saw that nursing staff put each tablet (or capsule) onto a spoon in order that people could take their medicines one at a time.

Other evidence
The purpose of this inspection was to look at concerns raised with us about the way some people were given their medicines. We also checked to see whether any action had been taken in response to the improvement action left following our previous compliance review in September 2011. We looked at people's medicines administration records being used at the time of our visit and spoke to the all the

qualified nurses on duty and some of the care staff.

The home had a policy for the covert administration of medicines. Covert administration means that medicines may be disguised to make sure that the person takes them. The policy stated that the method of administration will be agreed with the pharmacist. This will be clearly documented in the resident's / patient's care plan and on the medicines administration record sheet.

Staff told us that they crushed the medicines for one person to make sure that they would take them. We saw that this had been agreed with the person's doctor and also discussed with their relative. This person's care records showed that staff had recently requested that a healthcare professional come to assess whether this person was able to make an informed choice about whether to take their medicines.

There was no information to show that the method of administration had been agreed with the pharmacist, as stated in the home's policy. The method of administration had not been documented on this person's medicines administration record sheet. Two of the medicines that staff told us they crushed had information advising that they should be swallowed whole and not chewed. Staff told us that they had not checked with their pharmacist that it was safe to crush these medicines. While we were at the home staff spoke to the person's doctor, who reviewed their medicines.

Another person needed to have a large medicine broken into smaller pieces so that they could manage to swallow it. This medicine had information advising that it should be swallowed whole and not chewed. There was no information with the person's medicines administration record sheet to show how this particular medicine was given. A care plan in place for this person's medicines did not refer to them having difficulties swallowing their medicines. Staff told us they had not checked with their pharmacist that it was safe to break this medicine into pieces before giving it.

Some forms of medicines needed to be swallowed whole. Breaking them up or crushing them might result in them not working and they could cause people harm.

Staff told us that most people were given their medicines to take from plastic medicine cups. One member of staff told us that sometimes people living on the first floor of the home, who have dementia, might be given their medicines with some food.

We asked staff what action they would take if they realised a mistake had been made in giving medicines. They told us this would be reported to the manager.

We saw that action had been taken in response to the improvement action set in September 2011. People's medicines administration record had been completed appropriately. Protocols were in place for medicines that had been prescribed to be given 'when required' to provide additional information about how they should be given. This helps to make sure that these medicines are used safely and consistently.

Records for the use of people's creams and ointments were kept in their rooms. Care staff completed these when they applied the cream or ointment. However we saw that these records had not always been signed and did not show that these medicines had been used as prescribed by the doctor.

Our judgement
The service does not fully protect people against the risks associated with the unsafe use and management of medicines by means of the making of appropriate arrangements for the recording and safe administration of medicines. Records for the use of creams and ointments do not demonstrated that people have received these medicines as prescribed for them. Advice for the safe administration of some medicines had not been followed, this could cause people harm.

Outcome 13:
Staffing

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 sufficient numbers of appropriate staff.

What we found

Our judgement

There are moderate concerns with Outcome 13: Staffing

Our findings

What people who use the service experienced and told us
We were unable to speak with people who use the service about this outcome because they had dementia.

Other evidence
We had been told at our last visit to the home (on 21 September 2011) that staffing was calculated on a ratio of one staff member to five residents for those receiving nursing care and a ratio of one staff member to ten residents for those receiving residential care. We were told that night staffing was calculated on a ratio of one staff member to ten residents throughout the home. We confirmed that this was still the arrangement for staffing within the home. We reviewed the number of residents receiving nursing and residential care within the home in order to determine the number of staff to expect on each floor for each shift. We were told by the manager that there were usually two nurses covering the area where people with dementia are cared for, and one or two nurses covering the rest of the home on each day time shift.

The manager of the home confirmed that the dependency tool in place within the home was not used to calculate the number of staff required to meet the needs of the people within the home. This was identified at our last visit in September 2011 and an action plan had been put in place by the provider to rectify this.

We reviewed the staff rotas, staff signing in book and work allocation records for the week commencing 14 November 2011 and the staff rotas for the week commencing 21 November 2011.

We saw that on most days there were four nurses on shift during the day although on some days there was a senior nursing care assistant on shift rather than a nurse. We saw that on some days there were only three members of nursing staff (including the senior nursing care assistant) on shift in the afternoon. We saw that there were two nurses on shift for each night duty (one nurse for each floor). We saw that there were some nursing shifts which had not yet been covered for the week commencing 21 November 2011. The manager told us that they were working to cover those shifts either by using bank staff or agency staff if necessary.

We saw that on most shifts there were more staff scheduled to work on the general care floor than the dementia care floor even though the staff to resident ratio needed to be higher in the latter area to ensure people needs could be met appropriately.

When we arrived on the dementia care floor at 6.20pm we saw that there were five care workers and one nurse. There were two nurses and five care workers on the general care floor. According to the staff to resident ratios used by the provider, we would have expected to see seven members of staff in the dementia care area of the home and six members of staff in the general care area. We also saw the peripatetic manager overseeing the care provided on both floors.

We spoke with seven members of staff (in the dementia care area) about the staffing levels in the home. We were told by one member of staff that staffing levels had improved since September 2011 as senior management had employed more staff. They told us that sometimes there had only been four care staff and one trained member of staff on duty in the morning. They said "weekends were worst. We cannot guarantee who is going to be off sick. A lot of people call in sick here. There were a lot of people off sick yesterday. Not sure why. Possibly stress".

Another member of staff told us they believed that six care workers and one trained member of staff should be on duty from 8am until 8pm. They said the staff team were not clear at the moment about staffing levels. They told us "sometimes they had six care staff and one trained member of staff and yet one day last week they had eight care staff and two trained staff on duty".

This member of staff said they were short staffed on the day of our visit, as there were only five care staff and one trained staff member on duty. They told us that because they were short staffed "they could not assist some people to the dining room for the evening meal". They told us that the day staff had been told last week to take the meals to those who required assistance with eating a soft diet first at 4.45pm. Once that task had finished they were to assist those who needed support to go to the dining room for their evening meal. They told us that this had not happened on the day of our visit as they were short staffed. This member of staff confirmed that some people were were left to rest in bed all the day, others were assisted to bed early evening but some people chose to stay up. Another member of staff told us that it can take up to 45 minutes to support people eating their soft diets and the length of time depends upon the number of staff there are on duty. They told us that a lot of the people within the home like to go to bed early and this was reflected in their care plan.

Another member of staff also said they were short staffed on the day of our visit. They told us "this morning we had six care workers and one trained member of staff but from 2pm we only had four care workers and one trained member of staff". They said "we

were flat out all day and had no real breaks". They went on to say "we always seem to be short staffed. There is a lot of sickness and people are often late. That is the main problem here. People are stressed. People rang in sick today, not sure why, but people are stressed. We are now being asked to do more tasks such as the laundry, tea trolley. We could be spending more time talking to the people who live here or doing activities with them. If staffing levels are to work we need eight or nine care workers and one trained member of staff during the day".

We were told that two members of staff had not arrived for the night shift. One member of staff was delayed. The manager called other staff and an agency to cover these two shift. As a result there was an extra member of staff. Three members of staff arrived about 8.45pm and therefore missed the handover from the day staff.

The night staff told us that following handover at 8pm they had a plan to follow. They told us that the care workers split into two groups of staff. One pair worked separately, initially giving out hot drinks to people whilst the other care worker stayed in the lounge with the people who want to stay up after 10pm. The second pair assisted people to bed and made them comfortable, changing people's position as necessary. The trained member of staff administered the medication and completed the paperwork, but once she had finished those duties she would help care workers if busy. The pairs would then take it in turns to change people's position two hourly and assist people with personal care needs and drinks through the night.

We asked staff whether they had ever been asked to do an additional shift. All of the staff that we spoke with said that they had been asked to do an additional shift. Staff said that they did not feel pressured to do additional shifts but that they did get called regularly. Staff said that it was their choice if they did an additional shift.

We observed some of the care provided within the home to see if the staffing levels had an effect on the outcomes for people.

Staff we spoke with demonstrated a good understanding of people's needs, but appeared under pressure to fulfil care tasks due to minimal staffing levels. Despite minimal staffing levels we observed both day and night staff treating people with dignity and respect. We saw staff talking to people in a calm and clear manner taking their time with each person to ensure they were not rushed. We saw staff reassuring people when they became upset and respond to non verbal signs of distress. We heard staff using people's full names.

When we arrived at 6:20pm we saw that a number of people were in bed. We asked staff about this and were told that some people stayed in bed all the time. We asked the night staff about the number of people already in bed when they arrived on duty. They told us that when they started their shift at 8pm, a quarter of people were already in bed and this was for their safety as some of the people are at risk of falling. They said that between 8pm and 9pm the majority of people want to go to bed and another quarter wanted to stay up after 9pm.

We observed that people went to bed throughout the evening when they were ready. Staff sensitively reminded people of the time and asked them if they wanted to go to bed. We saw that people were not forced or coerced to go to bed. When we left the home at 11:20pm some people were still up and awake and there was no pressure

from staff for them to go to bed.

We saw people had drinks available in their rooms but some beakers were out of reach of people, for example, some people had soft mattresses on the floor by the bed (to protect them from injury if they fell out of bed) which prevented bedside cabinets being close to bed. We also saw that some people were not able to access their own drinks due to confusion or frailty. We saw staff were providing support to access those drinks. People who refused drinks were offered them later. We saw night staff offering drinks at 8.40pm and to those people who requested drinks later in the evening. We saw that food supplement drinks were offered to some people. This was confirmed in the majority of records. We observed that there were some gaps in the daily food and drinks records. However, we also saw evidence that people were given food and drink during the night if they wake up and are hungry or thirsty.

We were told that there are 19 people within the home who require support with eating. Of those people, eight were accomodated on the general care floor and 11 were on the dementia care floor.

We saw some people with dementia who were very frail and were always cared for in bedt. We saw some people who were frail but sat out of bed during the day and were returned to bed to reduce the risk of pressure sores. We saw equipment in place such as air mattresses and mattresses on floors to prevent people hurting themselves if they fell out of bed. We did not see hoists being used on this occasion. We saw both day and evening staff working in pairs to change people's position to reduce the risk of pressure sores.

We were told that there were only four people in the home who had pressure sores at the time of our visit. Two of these were grade one and two were grade two. We were also told that 41 people required two members of staff to assist in moving. Twenty two of those people were on the dementia care floor.

We reviewed the care plans for five people who were in bed when we arrived at the home. We saw that staff had documented in the care plans if people liked to go to bed early. We also saw evidence that where people were at risk of developing pressure sores their position was changed regularly. We saw that staff checked pressure areas daily and record if there is any redness or signs of skin break down or bruising. We saw the use of waterlow charts to assess people's risk of pressure sores. Information about pressure area care and risks for some people was limited. We could not find any evidence of the use of body maps to record areas of skin damage or records of bruising.

We were told by staff that there were new records (for recording food and drink consumption and turning of residents) that had been implemented that day. We saw a care worker filling in these records after supper.

We saw evidence of good team work and a supportive environment. The staff that we spoke with all said that they had not experienced any bullying within their work environment and that they felt supported by the current peripatetic manager.

Our judgement
People who use the service cannot be confident that the basis for deciding sufficient

staffing levels has been determined through the analysis of their combined needs and risk assessments. This means that people cannot be confident that there are suitable numbers of staff in place to support their needs. However, staff on duty have suitable knowledge about the people they are caring for and treat them with respect.

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 13 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 09: Management of medicines
	How the regulation is not being met: The service does not fully protect people against the risks associated with the unsafe use and management of medicines by means of the making of appropriate arrangements for the recording and safe administration of medicines. Records for the use of creams and ointments do not demonstrated that people have received these medicines as prescribed for them. Advice for the safe administration of some medicines had not been followed, this could cause people harm.	
Treatment of disease, disorder or injury	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 09: Management of medicines
	How the regulation is not being met: The service does not fully protect people against the risks associated with the unsafe use and management of medicines by means of the making of appropriate arrangements for the recording and safe administration of medicines. Records for the use of creams and ointments do not demonstrated that people have received these medicines as prescribed for them. Advice for the safe administration of some medicines had not been followed, this could cause people harm.	

Accommodation for persons who require nursing or personal care	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 13: Staffing
	How the regulation is not being met: People who use the service cannot be confident that the basis for deciding sufficient staffing levels has been determined through the analysis of their combined needs and risk assessment. This means that people cannot be confident that there are suitable numbers of staff in place to support their needs.	
Diagnostic and screening procedures	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 13: Staffing
	How the regulation is not being met: People who use the service cannot be confident that the basis for deciding sufficient staffing levels has been determined through the analysis of their combined needs and risk assessment. This means that people cannot be confident that there are suitable numbers of staff in place to support their needs.	
Treatment of disease, disorder or injury	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 13: Staffing
	How the regulation is not being met: People who use the service cannot be confident that the basis for deciding sufficient staffing levels has been determined through the analysis of their combined needs and risk assessment. This means that people cannot be confident that there are suitable numbers of staff in place to support their needs.	

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 7 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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