Oakhurst Court Limited

Oakhurst Court Nursing Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection was carried out on evening of 22 September 2017 and was unannounced. Oakhurst Court Nursing Home provides nursing care for older people and people living with dementia. The services also provides end of life care and respite care. On the day of our inspection 42 people lived at the service.

The registered manager was present on the evening of the inspection. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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. The Nominated Individual was also present at the inspection.

The service was last inspected on the 4 July 2017 where breaches of regulations were identified in relation to the lack of appropriate training and supervision for staff, risks that were not always being identified and managed appropriately ,the lack of mental capacity assessments, people not always being treated with dignity and respect, the lack of detailed care planning and the lack of effective governance. Recommendations were also made around how staff were deployed. At the inspection on the 4 July 2017 the service was rated as Inadequate and the service was placed into special measures.

After that inspection we received concerns in relation to the lack of infection control, the suitability of the environment and equipment, the lack of staff and the suitability of the management oversight of the service. As a result we undertook a focused inspection to look into those concerns. This report only covers our findings in relation to those topics. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Oakhurst Court Nursing Home on our website at www.cqc.org.uk.

People were not always protected from the risks of unsafe care. Staff did not adhere to basic infection control measures when needed to reduce the risks of cross-contamination. People were at risk of acquiring infections because appropriate action was not taken to reduce the risks of cross contamination. Areas of the service were untidy and in need of a deep clean. People's bedroom smelled strongly of urine. The premises and equipment at the service was not always stored or maintained appropriately to keep people safe.

The management of medicines was not always safe which put people at risk. The room where medicines were stored was not fit for purpose. There were errors on the medicine charts where it was not clear if people had received their medicines when needed.

People did not always have access to call bells and were unable to alert staff when they needed support. Staff levels at the service were not appropriate to support people when they needed.

People were not always treated with dignity and respect. People had to endure a strong smell of urine in their rooms. There were times where people were unable to access their rooms when they wanted. There

was a lack of stimulation for people living with dementia.

Quality assurance was not effective and there were no appropriate actions in place to address the standards of care that staff were providing. The provider had not met breaches in regulation from the previous inspection.

There was a lack of management oversight at the service. Staff were not being supported or supervised effectively.

The overall rating for this service is 'Inadequate' and the service remains in 'Special measures'.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

During this inspection we found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Medicines were not administered, stored and disposed of safely.

There were not enough staff at the service to support people's needs.

People were not always able to alert staff when they required support.

People were not always protected from environmental risks. Staff were not adhering to good infection control practice.

Is the service caring?

Requires Improvement

The service was not always caring.

Staff did not always treat people with dignity and respect. People had to endure the strong smell of urine in their rooms.

People were not always able to access their rooms when they wanted.

There was insufficient stimulation for people that were living with dementia.

Is the service well-led?

Inadequate

The service was not well- led.

The provider did not always have systems in place to regularly assess and
monitor the quality of the service the home provided. The provider had not met breaches in regulation from the previous inspection.

There was a lack of management oversight at the service. Staff were not being supported or supervised effectively.

Oakhurst Court Nursing 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. We carried out an unannounced comprehensive inspection of this service on 4 July 2017. After that inspection we received concerns in relation to the lack of infection control, the suitability of the environment and equipment, the lack of staff and the suitability of the management oversight of the service. As a result we undertook a focused inspection to look into those concerns.

This report only covers our findings in relation to those topics. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Oakhurst Court Nursing Home on our website at www.cqc.org.uk.

We undertook this unannounced inspection at 18.30 on 22 September 2017.

The inspection team consisted of two inspectors and a specialist nurse. Prior to the inspection we reviewed the information in relation to the incidents the provider notified us of. We were also provided with information from the Local Authority in relation to concerns that they had identified at the service.

During the visit we spoke with the registered manager, the Nominated Individual , one relative and four members of staff. We looked at a sample of three care plans of people who used the service, medicine administration records and audits that had been undertaken by the provider.

Inadequate

Is the service safe?

Our findings

On the previous inspections in July 2017 we had identified a breach in safe care and treatment. This related to risks assessments not always being in place for people and people not always having individualised equipment for moving and handling. We did receive an action plan from the provider to confirm that some equipment, for example slings, were not individual for people however we found additional concerns related to the safety of people at this inspection.

People were not always protected from the risks of unsafe care as staff did not adhere to basic infection control measures. There were red laundry bags with soiled linen and other dirty linen left on the floor in a room where a person had a contagious infection. Staff did not wear gloves or aprons when dealing with the linen used by the person which meant there was a risk of cross infection. There was no alcohol hand gel available at the service for staff to use in the person's room or other areas of the service. One member of staff told us "I believe that some has been ordered but has not arrived." The room of the person with the infection was untidy. The washroom facility was dirty and had rubbish on the floor. It was also cluttered and this made movement in that room and access to the washbasin difficult. There was no guidance on how the room should be cleaned in terms of frequency and type of detergent to be used which is important to ensure that the risks of spreading the infection is reduced.

People were at risk of acquiring infections. The laundry room was not set up to ensure that there was a designated area for the clean and dirty laundry to be handled. We observed a member of staff place a bag of soiled items in the washing machine with non-soiled items. In the laundry cupboards towels and bedding were stored on the floor and there was a stained pillow. The sluice rooms were untidy. The commode seat cover, lid and bowl in one person's room was dirty and stained with dried fluids. The cleaning room where equipment was stored was dirty and cluttered and trolleys that were used to carry cleaning equipment were not clean. One of commodes being used was rusted around the edges where people sat. The pedal bins in bedrooms and bathrooms were broken meaning staff and people had to use their hands to lift the lid. Staff had received training around infection control but were not observed to be putting this into practice.

The Provider contacted us after the inspection to confirm that they have implemented a number of systems and environmental changes to improve the laundry area and this will be checked when we inspect the service next.

The management of medicines was not always safe. The clinical room where medicines were stored was not fit for purpose. The room was dirty and did not conform to basic standards of safe storage of medicine. Medicine cupboards were either poorly labelled or not labelled at all. It was difficult to distinguish what medicines were not being used and those that were. Two bottles of medicine were left on the dirty floor and were labelled with the names of people currently living at the service. It was difficult to establish whether they were still in use. There was a medicine policy in the clinic room that stated, 'A clean as you go system operates, in other words after each drug round the responsible nurse should clean up behind themselves and once a month a full clearance and wash down of all cupboards must be undertaken.' This policy was not being followed by staff. Among other objects on the floor were yellow bins for sharps and needles. The

bins were full with no names of staff assembling them, dates of assembly or date closed which is practice that should be followed. The Director of the service told us that they were aware of the process but had not realised this was not happening.

The shelves in the clinic room were covered with dust and had boxes full with medicine cups, syringes (out of the packs), dirty spoons and empty packaging. It was difficult to establish what these were used for. In one corner there was a cupboard left open. On the floor there was a stack of a mixture of clinical equipment (old and new) including a suction machine. This had built up by staff placing things on top of each other rather that arranging them in an orderly fashion. There was a pill splitter in the clinic room used to cut tablets. There were traces of medicine still left on the instrument. If a pill splitter is not cleaned between uses, pill residue can contaminate the next person's medicines, risking an allergic reaction if the person has an allergy to the medicine residue.There was a risk that people would have their medicine contaminated.

The service medicine policy stated, ' A clean as you go system operates, in other words after each drug round the responsible nurse should clean up behind themselves and once a month a full clearance and wash down of all cupboards must be undertake. Medication pots…should be washed in hot soapy water in the sink by the nurse and left to drain on the drainer later to be returned to the clinic or room ready for the next administration. Medicine pots should not be left anywhere else for drying as it is unhygienic. The drainer is the appropriate place for this….plastic containers should be limited for essential use only as they appear to harbour dust and debris.' This was not being followed by staff.

There were gaps on seven of the Medicine Administration Charts (MARS) where staff had either forgotten to sign that they had administered the medicine or the medicine had not been given. We asked a member of staff about the gaps and they told us, "Staff should write the reasons (for medicines not given) at the back of the charts." However we when we checked there was no reason specified for the omission. We raised this with the registered manager who told us, "Yes, we are aware of this (the gaps in the charts) and we have asked the staff to come back in and sign the chart." This meant that staff were asked to sign the MAR chart retrospectively. This meant that it was assumed that people have taken their medicine without conducting an investigation of the incidents. Good practice would be that each incident should be investigated before arriving to a conclusion. Staff making medicine mistakes should undergo a competency test and supervision before being allowed to dispense medicines again. There was no evidence that this had taken place.

People were at risk as systems were not in place to ensure that when they needed staff they could alert them. There were people that were being cared for in their bedrooms and others that were already in bed when we arrived. People in their rooms did not have access to call bells to alert staff when they required support. One person told us that they had been waiting for staff to go in their room so that they could hand their tea plate to them. They told us that they had been waiting some time. Their bed was facing away from the door and they had no other way of attracting staff attention. We heard another person calling for help several times for approximately 30 minutes without any response from staff. We went into their room to reassure the person however for at least 10 minutes after we had left the room there was still no staff response. There was no call bell and no other means for the person to call for assistance apart from shouting. We did see that after 40 minutes a member of staff had gone into the room to attend to them. The registered manager said the call bells were stored on the tops of wardrobes and given to people when they went to bed. Despite this we did not see any evidence of this practice being followed by staff. This also did not account for people that were awake and sat in their chairs in their rooms.

Staff were not always given up to date information about risks to people. At the handover the nurse going off duty provided information to the care staff coming on duty. When handing over about people's fluid intake the nurse did not mention how much the person had consumed and whether this was below or

above the target amount. We checked the food and fluid charts and found that the target amount had not been calculated. Therefore the nurse did not have adequate information for staff to ensure adequate amount of fluid was taken. There were poorly completed records of people who required repositioning to reduce the risk of developing pressure wounds. Three people had not been repositioned which was required according to their care plan. One person needed to be repositioned every three hours. They were on their back for four hours before they were repositioned. Staff did not always check that people were comfortably positioned. For example one person had a cushion that did not support their weight and required replacing. It offered very little support to the person when they were sat on it as the cushion sank in the middle.

As care and treatment was not provided in a safe way and people were left at risk this is a continued breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The premises and equipment at the service was not always stored or maintained appropriately to help keep people safe. One person's room did not have a lid for their commode. In other rooms there was no toilet paper or toilet roll holders. There were fixtures and fittings in people's rooms that were damaged including one room where the sink top was damaged and a broken electrical socket on the wall. In another room there were hooks missing from the curtains and a large hole in the carpet in another person's room. In two rooms there were leads across the floor which presented a trip hazard. One of the wires was being pushed out of the way with the person's foot stool. Five of the bedrooms we went into did not have hot water in the bathrooms. The registered manager told us, "Sometimes the water runs out in the day. It shouldn't in the evening." The provider informed us after the inspection that the lack of hot water in the rooms had been addressed. The linen cupboards on the first floor were overflowing with bedding and were not stored neatly.

The provider notified us after the inspection that they were reviewing whether it was appropriate for people to have toilet rolls in their own bathrooms.

As the premises and equipment was not maintained to a safe standard this is a breach of regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were insufficient staff at the service to meet people's needs. Prior to the inspection we were made aware (by the Local Authority) of one person that was being funded for one to one care. However staff numbers had not been increased to allow for this. The registered manager and the provider had told us that an additional care staff had been allocated. However the rotas showed that eight care staff were working during the day. These were the same staffing levels allocated prior to the person requiring the one to one staff support. There was no information as to how staff were allocated to work. One member of staff told us, "We don't allocate these hours; we blend it around what we are doing." They told us that the person's behaviour was better during the day but at night was still an issue.

At the handover at 20.00 hours the care staff numbers reduced from eight to four. At the time of the handover there were at least 15 people that still required support to go to bed. At 22.00 hours the care staff reduced to three and there were still at least eight people still in one of the lounge area being supported by one member of staff. They were left on their own and were attempting to assist a person to sit down whilst avoiding tea on the floor that had been spilled. They were also trying to stop another person taking someone's cup of tea from them. Another person took a cake from a person which was not observed by the member of staff as they were busy elsewhere.

The registered manager and provider was unable to tell us why only three care staff were required in the evenings given so many people still required support. The registered manager told us that it was not unusual for this many people to still be up as it was their choice to go to bed when they wanted. The

registered manager told us that the fourth member of staff that had left at 22.00 hours had only been asked to stay on as we were inspecting. The member of staff concerned also confirmed this with us. The registered manager told us that they had intended to introduce a 'twilight' shift to assist with care at night but had not yet organised this. They also told us that three care staff at night was not sufficient and that, "The impact is that (people are) not being cared for properly."

Our observations were that staff were rushed and at times left people unsupported in the lounge as they were busy providing support elsewhere. On other occasions there was one member of staff left downstairs to support 15 people only supported by the provider who would not normally be working. This left two care staff to support people that were in their beds who required repositioning. However this also meant that whilst they were supporting people on one floor there were no staff present on the other floor where people were in their rooms. All of the night staff confirmed that there were not enough staff to support people. We asked what impact this had on the care delivery. One member of staff said, "We don't have time to wash people at night." They told us that people were supported to bed without a wash. Another member of staff said, "It's hard, you need eyes in the back of your head. Sometimes it can be unsafe." A third told us, "Of course three carers is not enough. We are rushing the care." We noted that six people had been supported to bed by staff and were still wearing their day clothes.

There were not sufficient clinical staff at night to support people. One nurse told us, "It takes me at least two hours to complete the medicine round. It can be very difficult. For example tonight whilst doing the medicine, I have to check every half an hour that the person with end of life care is receiving the care (the person) has been prescribed, I have to respond to the queries of the carers, answer phone calls, help with the people who are restless and sometimes challenging." There was clearly a need for a second nurse at night to support 42 people. There was a risk that nursing staff could be distracted and medicines errors could occur.

After the inspection the provider told us that they had increased the care staff at night by one and had introduced a 'twightlight' carer to assist for the part of the evening.

As there were insufficient staff to support people's needs this is a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were aspects to the delivery of medicines that were safe and appropriate. We observed the nurse dispensing medicine. They were both knowledgeable and skilful and communicated well with the people when giving medicine. They carefully checked the medicine against the MARS. They checked that they had the right person by calling the person by their name and when giving medicine to a person with the risk of choking they made sure that they mixed the water with the thickener. When administering insulin the nurse tested the person's blood sugar levels and checked this against the instruction by the doctor before administering the insulin. After each administration they entered their signature to indicate that they had given the medicine before moving on to the next person.

There were aspects to the management of risks that were appropriate. Wound dressings were clean and changed regularly by the nurse. Photograph taken regularly showed the progress and improvement of the wound. There was also involvement of the district nurse and the GP. The person was referred to the tissue viability nurse and the staff were following on with the care advised from this referral. People with the risks of pressure ulcers were nursed on pressure mattresses, the setting were appropriate to their weights. The nurse told me that the check the mattresses daily and we confirmed this. People were protected from the risks of falls from their beds. People had falls and bed rails risk assessment in place. Beds were fitted with bed rails and bumpers to prevent them from falling and entrapment.

Requires Improvement

Is the service caring?

Our findings

On the previous inspections in July 2017 we had identified a breach of regulations in relation to dignity and respect. Staff did not always understand people's cultural needs and people were being hoisted in full view of other people. At this latest inspection we continued to find concerns around dignity and respect.

People were not always treated with dignity and respect. At the previous inspection in July 2017 it was identified that there was a strong smell of urine in some people's rooms. This had still not been addressed. There were several mattresses in people's rooms that smelled strongly of urine. The smell at times was overwhelming yet people were sleeping on these mattresses. People were not given separate flannels to wash with. Prior to the inspection the provider told us that the practice of staff using communal flannels for people had been stopped. However on the night of the inspection a member of staff confirmed that this was still happening. They said, "We wash people with the flannel from the laundry or use wipes if they prefer." They showed us the pile of flannels that were used which they had brought up from the laundry room.

The provider informed us after the inspection that new mattresses had been purchased for people and a deep clean had taken place. We will check the effectiveness of this at our next inspection.

People were not always supported with their independence and autonomy. There was one person who was unable to access their bedroom during the day as it was locked. The registered manager told us that this was because their family wanted the door locked to prevent other people from entering the room. However this meant that the person was unable to access their bedroom during the day when they wanted. Although we did not see the person try to access the room the registered manager told us that they knew that locking the person's door during the day was, "Unsatisfactory." However no actions had been taken to address this.

During the inspection there were people that remained in their rooms. There was very little interaction from staff and people were left isolated. Socially isolated people can become withdrawn. We saw people sat in their room for the duration of the inspection with very little stimulation to keep them occupied. Some people in their rooms had stained clothes and their appearance was not well maintained.

People did not always have access to stimulation. There were people at the service that walked continuously. There were no areas of stimulation or destinations areas for people to be involved in. Keeping the person who is living with dementia active and engaged can help discourage this behaviour by reducing anxiety and restlessness. This demonstrated a lack of understanding of the needs of people living with dementia.

As people were not always treated with dignity and respect this is a continued breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Appropriate care was being provided to a person was at the end of their life. The relative of the person told us, "I have a lot of admiration for the staff. They have been very good to me and my (family member). They have offered me a room. My (family member) is in good hands, they come in at different times to change (the

person), to make them comfortable. He has not shown any sign that he is in pain. The doctor comes in regularly to review his care. He has been here for the past two years and I don't have any cause for any complaints". On observation the person appeared comfortable and well dressed. The room was well lit, clean and tidy and did not have any unpleasant odour and the bed clothes were clean. The person lips were moist and records confirmed that staff had been giving oral care regularly and moistening the person's lips every 30 minutes.

We did see occasions where staff were considerate to people. One person was seen with their trousers coming falling down. Staff responded to this straight away and assisted the person with their trousers. Staff were seen to ask people if they wanted to go to bed rather than not giving them choice. Where people said they did not want to go to bed this was respected by staff. When the nurse administered medicines they introduced themselves to people and greeted them warmly.

Inadequate

Is the service well-led?

Our findings

Quality assurance were not effective and had not identified the concerns we found during the inspection. After the inspection on 4 July 2017 the provider sent us an action plan on 30 July 2017 to detail what improvements were going to be made and the deadline for these actions. The action plan stated that memory boxes should be used outside people's rooms. The deadline for the action was monthly and on-going however these were not in place on this inspection. There were no memory boxes outside people's rooms. The action also stated, 'Tackle malodours, complete a full review of continence, consider aids, address and supervise housekeeping.' The deadline for this action was the 11 August 2017. This had still not been addressed. We found that some rooms still had a strong smell of urine and the housekeeping cupboard and room were still untidy and not clean. The action plan stated, 'Review medication and audit regularly.' They told us that this would be addressed by the end of August 2017. However we still found concerns with how medicines were being administered. The clinic room required cleaning and re-organising. The registered manager could not locate the medicines audits and told us that these would be sent. However to date these have not been received.

There were not effective systems set up to assess and monitor the care being provided by staff. A meeting took place on 6 June 2017 where staff were reminded to 'Ensure all residents have call bells in their rooms particularly when they are in bed, or in their rooms.' This was still not happening on the evening of the inspection as we found people in their rooms without access to a call bell. There were no systems in place to ensure that staff were taking the actions that they had been reminded of. There were no checks in place or audits being undertaken to ensure that call bells were always available to people in their rooms. The infection control policy stated clearly the actions that needed to be taken to ensure that staff were following good infection control. We found that this was not happening.

Where shortfalls had been identified, action was not always taken to rectify this. We were informed by the local authority quality assurance team of a visit that they undertook at the service on the 14 September 2017. They identified concerns that were fed back to staff and the registered manager on the day. These concerns related to the lack of infection control by staff, the laundry room and housekeeping room being untidy, the lack of staff, the clinical room being untidy and the smell of urine. However on the 22 September 2017 when we visited these concerns had still not been addressed. An internal audit was undertaken by the provider on 10 August 2017 where poor standards of cleanliness had been identified and the smell of urine in the rooms. However the action plan did not detail how they were going to address the smell of urine other than to 'Spring clean the entire home.'

There was a refurbishment plan in place at the service that detailed actions the provider was taking. This included the replacement of bathrooms, flooring, furniture and soft furnishings. This refurbishment plan had not included any actions to address faulty equipment that we had identified at the inspection. The provider undertook a further audit of the service on the 31 August 2017. This was conducted by a manager from another of the provider's services. The audit did not identify the significant environmental concerns that we had identified on this inspection. For example, the audit stated that 'Still slight malodours to tackle…review ventilation.' The smell of urine was strong and it was evident that the smell was coming from people's

mattresses and ventilation in rooms would not have been sufficient to alleviate this. There were no actions in any of the audits we reviewed that highlighted the need to replace mattresses.

There was a lack of management oversight at the service. Staff were not being supported or supervised effectively; staffing levels were not monitored to ensure that people's needs were met. Routines were not established for staff and action plans were not being followed by the registered manager. During the handover the nurse mentioned the names of people to the oncoming staff but made very little reference to the care plans and the outcome of the care given in a consistent manner. The care staff did not take any notes of the care people required but instead they relied on memory. Carers were not allocated to people prior to the hand over.
As systems and processes were not established and operated effectively this is a continued breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

After the inspection the provider notified us that a deep clean of the service had been undertaken. They advised us that new mattresses were going to be ordered. We will check this at the next inspection.