De Vere Care Limited

# Oakwood House Residential and Nursing Home

## Inspection report

Oakwood House
Stollery Close, Kesgrave
Ipswich
Suffolk
IP5 2GD

Tel: 01473840890

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08 October 2019

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12 November 2019

## Ratings

| | |
|---|---|
| Overall rating for this service | Inadequate |

| | |
|---|---|
| Is the service safe? | **Inadequate** |
| Is the service well-led? | **Inadequate** |

# Summary of findings

## Overall summary

Oakwood House Residential and Nursing Home is registered to provide care and support for up to 24 people. There were 22 people living in the service on the day of our inspection visit.

People's experience of using this service and what we found
Medicines were not managed and administered safely. Medicines were not always available when required and people did not always receive their medicines as prescribed.

Care plans did not always contain information as to how risk was managed and where this was in place it was sometimes contradictory putting people at risk of receiving unsafe care. Since our previous inspection in August 2019 some improvements had been made to the maintenance of the premises, particularly around cleanliness. However further improvements were still needed to ensure people's safety.

After our inspection we met with the provider to discuss improvements they planned to make to the management of the service following our inspection in August 2019 and this inspection to ensure improvements to safety and the management of risks at the service. Whilst they were able to tell us about changes they had made to the senior management team and plans they had in place to make improvements there were no specific time scales for improvements. Actions had not been prioritised to mitigate the more serious risk identified.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk
Rating at last inspection (and update) The last rating for this service was Inadequate (published 1 October 2019) and there were multiple breaches of regulation. At this inspection enough improvement had not been made and the provider was still in breach of regulations.

Why we inspected
We received concerns in relation to the management of medicines, staffing and how people's care needs were met. As a result, we undertook a focused inspection to review the Key Questions of Safe and Well-led only. Ratings from previous comprehensive inspections for those Key Questions were used in calculating the overall rating at this inspection. The overall rating for the service has not changed from Inadequate. We have found evidence that the provider needs to make improvements. Please see the Safe and Well-led sections of this full report.
You can see what action we have asked the provider to take at the end of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Oakwood Residential and Nursing Home on our website at www.cqc.org.uk.

Enforcement
We have identified breaches in relation to premises safety, medicines and the overall management at this inspection.

Please see the action we have told the provider to take at the end of this report. Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
We will request an action plan for the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

Special Measures
The overall rating for this service is 'Inadequate' and the service remains in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe. And there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the 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.

## 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.

Details are in our safe findings below.

### Is the service well-led?

**Inadequate**

The service was not well-led.

Details are in our well-Led findings below.

# Oakwood House Residential and Nursing Home

**Detailed findings**

## Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

Inspection team
This inspection was carried out by three inspectors. One was a specialist medicines inspector.

Service and service type
Oakwood House Residential and Nursing Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service did not have a registered manager in post.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the home since the last inspection. We sought feedback from the local authority and professionals who work with the home.

The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

We used all of this information to plan our inspection.

During the inspection
We spoke with the manager and a representative of the provider.

We reviewed a range of records. This included four people's care records, medicine administration records and associated records for 15 people. We spoke with four members of staff about medicines and observed a member of staff giving people their medicines.

Inadequate

# Is the service safe?

## Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as Inadequate. At this inspection this key question has remained the same. This meant people were not safe and were at risk of avoidable harm.

Systems and processes to safeguard people from the risk of abuse

- Our inspection in August 2019 found that only 14 of 53 eligible staff had received safeguarding training. At this inspection records demonstrated that only 11 of 46 eligible staff had received safeguarding training. The provider had failed to take prompt action to address this shortfall in training between our inspections.
- The manager in post at this inspection had made appropriate safeguarding referrals.

Assessing risk, safety monitoring and management

- Care plans did not always contain information as to how risk was managed and where this was in place it was sometimes contradictory putting people at risk of receiving unsafe care. For example, one person had lost 13kg in the past nine months. Their Drinking and Eating care plan record their expected outcome as 'To provide adequate nutrition and hydration without any weight loss'. It did not record any actions regarding their weight loss. For another person they had been referred to the Speech and Language Therapist (SALT) regarding their choking risk. The advice received from the SALT was not reflected in their care plan.

The service was not effectively assessing and managing risks. This placed people at risk of unsafe care. This was a continued breach of regulation 12 (Safe) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection in August 2019 and the previous inspection in January 2019 we found the provider had failed to properly and safely maintain the environment. This was a breach of regulation 15 (Premises and Equipment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found insufficient improvement had been made and the provider was still in breach of regulation.

- There were still holes in the walls in three en suite bathrooms where pipes had been boxed in. This allowed access to hot pipes and did not allow for effective cleaning.
- There had been some improvement to the cupboards we had identified in our January 2019 and August 2019 inspections as being in a state of poor repair. However, there was still chipped and broken laminate and chipboard under the laminate was exposed.
- The provider had reported an incident where a person had left the service by going through the rear fence. They told us that the fence had been repaired. At this inspection we found that one of the fence posts was held in place by a cord tied to a tree and two other posts were rotten and wobbly and could have easily been pushed over.
- At our previous inspection in August 2019 the provider had told us they planned to start improvement works in communal areas in September. At this inspection they had not taken place.

Systems were either not in place or robust enough to demonstrate maintenance was effectively managed. This placed people at risk of harm. This was a continued breach of regulation 15 (Premises and Equipment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The manager told us that they had employed a new maintenance person who would be starting work in the next couple of weeks and they were confident that the concerns would be addressed.
● Risks to people with regard to malnutrition, pressure care and choking were not always effectively assessed and managed. For example, one person had been identified as at risk of choking there were contradictions in the care plan as to the consistency of food they were safely able to eat. For another person who had been assessed as at high risk of developing pressure ulcers there was no information in the care plan as to how the risk was mitigated.
● Whilst some risks had been identified the need to address the more serious risk as a priority had not been recognised. For example, one care plan was being completely re-written whilst other care plans contained risks which were not been addressed.

Staffing and recruitment
At our last inspection in August 2019 we found the provider had failed to employ sufficient appropriately qualified staff. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found insufficient improvement had been made and the provider was still in breach of regulation.

● On the day of our inspection visit the manager was not available when we arrived at 9.30am. We approached the senior nurse on duty who told us she was not the responsible person in the manager's absence. We could find nobody suitably qualified and competent who was running the service at that time.
● The manager told us that on the day of our inspection visit the service was fully staffed. However, we observed several periods of up to 30 minutes in one of the units where there was only one member of staff on the unit. Staff and people using the service were put at risk because one person on this unit was experiencing a deterioration in their mental health and was displaying behaviours staff found increasingly challenging.

There were insufficient suitably qualified staff on duty to run the service and provide care and support in a safe environment. This was a continued breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The manager told us that they were actively recruiting new staff. They had identified nurses and care staff who were going through the recruitment process.

Using medicines safely

At our last inspection in August 2019 we found that medicines were not managed safely, and people did not get their medicines as prescribed. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found insufficient improvement had been made and the provider was still in breach of regulation.

● Oral medicines given by staff were recorded on Medicine Administration Record (MAR) charts. However, we noted that there were gaps and discrepancies in the records where medicines could not be accounted for and where the records did not confirm that people received their medicines as prescribed.
● Observations of staff giving people their medicines at the time of inspection showed that they followed

safe procedures, however, we saw that some medicines were not given to people because they were not available and had not been obtained. Records showed that there were ongoing issues with medicine availability that meant people did not always receive their medicines placing their health and welfare at risk. We asked the manager to take urgent action to obtain medicines currently unavailable and to resolve ongoing medicine supply problems.

•There was written guidance to show staff how people preferred their medicines given to them and personal identification to assist staff give people their medicines safely. However, some information about their known allergies and medicine sensitivities was written inconsistently which could have led to these medicines given in error.

● There was some written guidance to help staff give people their medicines prescribed on a when required basis, however, we noted this frequently lacked person-centred detail to ensure staff gave them to people consistently and appropriately. For people prescribed more than one medicine to be given on this basis for similar reasons there was a lack of the overall strategy for the use of each medicine. In addition, when these medicines were given to people, there was sometimes a lack of recorded information to show the use of the medicines was justified or that they had been effective.

● Records showed that when people refused their medicines or were not given them because, for example, they were still asleep in the mornings, there were frequently no later attempts by staff to give them.

● When people who would otherwise refuse their medicines were given them hidden in food or drink (covertly), there were records showing that appropriate people and professionals were consulted. However, proper assessments of their mental capacity had not been carried out to ensure they lacked the mental capacity to make decisions for themselves.

● For people who were prescribed medicated skin patches there were additional records in place to show the sites the patches had been applied to had been varied to reduce the potential for skin side effects. However, these had not always been completed by staff and some records that had been completed did not show the patch application sites had been varied appropriately.

● When medicines were to be given to people at specific times such as medicines for Parkinson's disease there was a lack of systems in place to ensure staff gave people their medicines at the exact times intended by prescribers. We also noted that one person prescribed a pain-relief skin patch did not have it applied until a day later than scheduled which may have led to them receiving inadequate pain-relief.

● The manager confirmed that at the time of inspection there were no systems in place for checking and monitoring people's medicines and their records to ensure that errors and incidents arising could be promptly identified and action taken to resolve them.

Medicines were not managed safely, and people did not get their medicines as prescribed. This was a continued breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Oral medicines were stored securely and at correct temperatures.

● The manager told us that they had recognised the issues with medicines and would be implementing a new management and administration system the next week.

Preventing and controlling infection

At our last inspection in August 2019 and the previous inspection in January 2019 we found the provider did not have adequate infection control measures in place. This was a breach of regulation 12 (Safe) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found sufficient improvement had been made and the provider was no longer in breach of regulation.

● Since our previous inspection the service had implemented new systems for checking cleaning. At this

inspection we found the service to be clean with no unpleasant smells.
● We did however, identify one bath chair which was stained and one which had a split cover to the back rest, meaning it could not be effectively cleaned.

Learning lessons when things go wrong
● The manager told us how they were working to improve the service. They had recognised some of the failings we had identified and were beginning to put actions in place. However, due to the short time they had been in post improvements had not yet been made.

Inadequate

# Is the service well-led?

## Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as Inadequate. At this inspection this key question has remained the same. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

At our last inspection in August 2019 and the previous inspection in January 2019 we found the provider had failed to asses, monitor and improve the quality and safety of the service. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found insufficient improvement had been made and the provider was still in breach of regulations.

● Since our previous inspection in August 2019 the manager had left and been replaced by a new manager. The new manager had been in post for four weeks on the day of this inspection. This meant there had been three managers at the service since our inspection in January 2019.
● Whilst improvements were planned, there were no clear timescales and work was not always being prioritised according to the most risk. For example, neither the provider nor manager had an oversight of the individual risks to people and work was being focused on personalisation and not the mitigation of risk.

● At our previous inspection in August 2019 we had found that management roles were not clearly defined and when the manager was not present there was no clear leadership and lines of responsibility in place. At this inspection we found that this continued with senior staff on duty abdicating responsibility for leadership roles.
● The new manager told us that they were engaging with the staff team and believed morale within the staff team had improved. However, they gave us an example of documentation that had 'disappeared' and had needed to be re-written. This was a continued problem from our previous inspection.
● The provider told us that following our August 2019 inspection they had recognised shortfalls in the senior leadership team and had reorganised this in response. However, there had been insufficient time since our last inspection for improvement to be demonstrated. There had been ongoing failures in the service since November 2017 and previous assurances regarding improvement had not been met.

The service was not effectively managing risk and improving quality. This placed people at risk of harm. This was a continued breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● Our previous inspection in August 2019 had identified concerns from staff that the senior management team did not engage with them and that they did not feel valued.

● The new manager and the provider's representative told us how they were engaging with the staff team to improve morale. However, there had been insufficient time since our last inspection in August 2019 for improvement to be demonstrated

● Since the inspection visit we have received positive comments from a relative regarding the new manager.

Continuous learning and improving care

● Since this inspection visit we have met with the provider and members of the senior management team. They told us how they plan to improve the service following our inspection of August 2019. However, due to the short time between that inspection and this, improvement could not be demonstrated.

Working in partnership with others

● The local authority had been supporting the service to improve and moving and handling training was planned.

● The manager told us that following the implementation of the new medication process they would be working with the local medicines' optimisation team.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

● Following the publication of our August 2019 report the provider had engaged with relatives regarding the content.