Mondial Care Ltd

Oakland Nursing Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Oakland Nursing Home is a nursing home providing nursing and personal care to up to 27 older people, some of whom have physical disabilities or sensory impairments. At the time of our inspection there were 13 people using the service.

People's experience of using this service and what we found
The provider had failed to implement effective quality assurance processes. They did not have sufficient oversight of the service being provided.

The provider failed to make required improvements following the last inspection and a number of issues remained at this inspection. The provider had not regularly engaged with people, relatives or the staff team or requested feedback to improve the quality of the service provided.

Risks to people had not been consistently monitored, recorded and action had not always been taken to prevent risks from reoccurring. Equipment and safety checks had not been completed to ensure they remained safe to use.

Safe recruitment processes were not followed. Required pre-employment checks had not always been completed prior to new staff commencing employment.

Medicines had not been stored, recorded or administered appropriately. Not all nursing staff had been observed to ensure they were competent with regards to medicine management.

Records used to monitor people's health and wellbeing had not been completed consistently. We could not be assured people were receiving sufficient fluids.

People told us they felt safe. Processes had been followed to ensure any concerns related to suspected abuse were appropriately reported.

People were supported to have maximum choice and control of their lives and staff them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

For more details, please see the full report which is on the Care Quality Commission's (CQC) website at www.cqc.org.uk

Rating at last inspection and update
The last rating for this service was requires improvement (published 13 April 2021) and there were breaches of regulations. The provider completed an action plan after the last inspection to show what they would do

and by when to improve. At this inspection we found the provider remained in breach of regulations.

The service remains rated requires improvement. This service has been rated requires improvement for the last two consecutive inspections.

Why we inspected
The inspection was prompted in part due to concerns received about the quality and safety of the service being provided. We also received concerns in relation to the management and provider oversight of the service. A decision was made for us to inspect and examine those risks.

We looked at infection prevention and control measures under the safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

We have found evidence that the provider needs to make improvements. Please see the safe and well-led sections of this full report.

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating.

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 Oakland Nursing Home on our website at www.cqc.org.uk.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to monitor the service and will take further action if needed.

We have identified breaches in relation to assessing risks, safety of the service, recruitment processes and monitoring systems in place at this inspection.

Please see the action we have told the provider to take at the end of this report.

Follow up
We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always 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.

Oakland 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 Health and Social Care Act 2008.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection was conducted by one inspector. An Expert by Experience made calls to people and relatives following the site visit, to ask their views on the service provided. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
Oakland Nursing Home is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Oakland Nursing Home is a care home with nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

This service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

At the time of our inspection there was not a registered manager in post. An interim manager had recently been appointed. They are referred to as 'the manager' throughout this report.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We used information gathered as part of monitoring activity that took place on 20 October 2021 to help plan the inspection and inform our judgements. We sought feedback from the local authority and professionals who work with the service. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We spent time observing staff interactions with people. We conducted a tour of the service and looked in people's bedrooms as well as communal spaces. We spoke with four members of staff including the new manager, a nurse and two care staff.

We reviewed a range of records. This included five people's care records and multiple medication records. We looked at two staff files in relation to recruitment. A variety of records relating to the management of the service were also reviewed.

After the inspection
Following the inspection site visit an Expert by Experience contacted six people who used the service and four relatives via telephone to ask their views on the service provided. We contacted the nominated individual via email to request records that were not available in the service and to validate evidence we found. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

Requires Improvement

Is the service safe?

Our findings

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

At our last inspection we rated this key question requires improvement. The rating for this key question has remained requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Assessing risk, safety monitoring and management

- Risks to people had not been consistently monitored, recorded and action had not always been taken to prevent risks from reoccurring. Some risk assessments contained conflicting information.
- Checks to ensure the safety of equipment were either not in place or had not been completed consistently. For example, there were no checks of wheelchairs to ensure they remained safe and no evidence the nurse call and fire alarm system had been serviced.
- Records used to monitor people's health were not completed consistently. For example, there were gaps in fluid intake records so we could not be assured people were receiving sufficient fluids. When people required support with re-positioning due to increased risk of pressure damage, these had not always been recorded.

Failure to assess the risks to the health and safety of service users and failure to do all that is reasonably practicable to mitigate any such risks is a continued breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely

- Medicines were not always stored and recorded appropriately.
- Records for prescribed topical medicine such as creams, did not always provide staff with detailed guidance on how and where to apply.
- We found prescribed topical medicines were not always stored appropriately. For example, one person's medicine was stored in another person's bedroom.

- Medicine records had not always been completed when medicines were administered.
- The provider had failed to ensure all staff responsible for administering medicine were competent to do so.

Failure to safely manage medicines is a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Learning lessons when things go wrong

- Lessons had not been learnt went things went wrong. A number of shortfalls that were identified at the last inspection remained at this inspection.
- There was insufficient management and provider oversight with regards to accidents and incidents. This

meant lessons had not been learnt and risk assessment had not always been updated to reduce the risk of reoccurrence.

Failure to do all that is reasonably practicable to mitigate any such risks is a continued breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment
● A safe recruitment process was not followed.
● Appropriate references had not always been requested prior to employment commencing and gaps in employment history had not been explored. Where police cautions had been disclosed, risk assessments had not been completed to ensure they were suitable to work with vulnerable people.
Failure to established and operated effective recruitment procedures is a breach of Regulation 19 (Fit and proper persons employed)) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Observations showed there was enough staff on duty to support people. Calls bells were answered in a timely manner. One person said, "I have a call bell, but I usually just shout the staff and they come quickly. There's always plenty of staff around."
● The home was currently using a high number of agency staff to ensure they could meet safe staffing levels. The manager had introduced an agency staff induction to ensure they had access to relevant information, policies and procedures before they commence working in the service.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The MCA requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the Mental Capacity Act (MCA). In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS)
● We found the service was working within the principles of the MCA and if needed, appropriate legal authorisations were in place to deprive a person of their liberty. Any conditions related to DoLS authorisations were being met.

Systems and processes to safeguard people from the risk of abuse
● System and processes were in place to safeguarding people from the risk of abuse. These processes had been followed.
● Staff have received safeguarding training and were familiar with the process they needed to follow to report any suspected abuse.
● People told us they felt safe living at the service. Comments included, "I feel safe living here" and "Nobody upsets me here." A relative said, "I have no concerns about safety and no problems with any of the staff. They talk to [person's name] when they're in the hoist, so they feel safe."

Preventing and controlling infection
● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was meeting shielding and social distancing rules.
● We were assured that the provider was admitting people safely to the service.

● We were assured that the provider was accessing testing for people using the service and staff.
● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.
● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
● We were assured that the provider's infection prevention and control policy was up to date.
● We were somewhat assured that the provider was using PPE effectively and safely. Observations showed some staff were wearing their face mask below their chin.

We have also signposted the provider to resources to develop their approach.

Visiting in care homes
● Government guidance in relation to visiting in care homes was being promoted and followed at all times. A relative told us, "I can visit whenever I want with no restrictions. If the weather is nice I take my relative out."

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 our last inspection we rated this key question requires improvement. At this inspection the rating has changed to inadequate. 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; Continuous learning and improving care

- Appropriate and effective systems were not in place to monitor the quality and safety of the service.
- The provider had failed to ensure they had effective oversight of the service. Although they visited the service on a regular basis, they did not complete any audits to monitor the service being provided.
- The provider had not ensured effective management arrangements were place in the absence of the registered manager. This meant audits previously introduced had not been completed consistently and did not highlight the concerns found at this inspection.
- The provider failed to make improvements following the last inspection to ensure compliance with regulations. Shortfalls identified at the last inspection remained at this inspection.

Failure to establish and operate effective systems to assess, monitor and improve the service provided is a continued breach of Regulation 17 (Good Governance) of the 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

- The provider did not actively engage with people and staff to seek their views. People, staff, relatives or professionals had not been asked to provide feedback on the service provided.
- Regular residents, relatives and staff meeting had not taken place. One person said, "We don't have any meetings and don't really get told about anything to be honest. I am optimistic things will improve when the new provider takes over."
- In January 2022 the provider had notified people, relatives and staff that the service would be transferring to a new provider. At the time of the inspection, the transfer was still ongoing. This had caused distress and anxiety to people, relatives and staff.

Failure to seek and act on feedback from people, relatives and staff is a continued breach of Regulation 17 (Good Governance) of the of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- Staff reported the morale within the service had been very low. Staff did not feel empowered, and the lack of management support meant positive outcomes were not always achieved.

● Staff were committed to the service and the people they supported. They were optimistic that improvements would be made now that a new manager was in post.
● At the time of this inspection the new manager had been in post for three weeks. People and relatives spoke positively of the new manager. Comments included, "It is getting better here now. The new manager interacts more with us" and "The new manager is very good. He talks to me, and more importantly he listens to what I say."

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
● The provider had not always been open and honest when things had gone wrong. We found one complaint had still not been appropriately responded to.

Working in partnership with others
● The service was currently receiving support from the local authority to make improvements. However, due to the lack of management within the home, little progress had been made.
● Records showed that staff had taken action to report any concerns with regards to people's health and wellbeing to relevant professionals in a timely way.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider failed to assess and mitigate the risks relating to each service user. The provider failed to ensure the premises were safe to use for their intended purpose. The provider failed to ensure the proper and safe management of medicines. 12(2)(a)(b)(c)(d)(g)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to establish and operate effective systems to assess, monitor and improve the service provided. The provider failed to seek and act on feedback provided. 17(1)(2)(a)(b)(c)(e)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider failed to established and operated effective recruitment procedures. 19(2)