Care Quality Commission

Precious Healthcare Ltd

# Oakleigh House Nursing Home

## Inspection report

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Tel: 02084215688

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25 June 2018
26 June 2018

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## Ratings

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

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

# Summary of findings

## Overall summary

This inspection took place on 21, 25 and 26 June 2018. We arrived on the 21 June 2018 early in the morning and did not announce our inspection. We told the registered provider that we would need to visit again on 25 and 26 June 2018.

During our previous inspection on 14 & 15 June 2017 we rated Oakleigh House Nursing Home as 'Requires Improvement' and found five breaches of the Health and Social Care Act (HSCA) 2008 (Regulated Activities) Regulations 2014. We found that the premises and equipment used was not secure, clean and suitable for carrying out the regulated activities, Regulation 15 premises and equipment. We found that people who used the service were not always protected from detecting and controlling the spread of infection, Regulation 12 safe care and treatment. We found that the treatment and care provided did not always reflect peoples assessed needs, Regulation 9 person-centred care. We found that the registered person failed to have an effective system in place to monitor and assess the quality of care and make improvements because of these quality assurance measures, Regulation 17 good governance. We found that treatment and care was not always provided in a safe way and the registered provider did not take reasonable steps to mitigate such risks, we served a warning notice for Regulation 12 safe care and treatment.

Following our comprehensive inspection in June 2017, the service submitted an action plan detailing how they would improve to ensure they met the needs of the people they were supporting and the legal requirements.

We undertook a focused inspection on 3 October 2017 to assess the breach of regulation 12 in relation to inadequate risk assessments to ensure people were safe from receiving inappropriate care. At this focused inspection, we found that the service had followed their plan and legal requirements had been met. We found that risk assessments were in place for areas such as pressure ulcers, falls, epilepsy and diabetes. There were measures in place to give guidance to staff on how to manage risks. There was evidence the risk assessments were reviewed regularly to ensure they remained relevant and reflective of people's needs.

Oakleigh House Nursing Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. Care Quality Commission (CQC) regulates both the premises and the care provided, and both were looked at during this inspection.

Oakleigh House Nursing home is registered to provide accommodation and nursing care to maximum of 20 people. At the time of this inspection 17 people were living at the home.

At the time of our inspection there was no manager registered with the CQC. The registered manager left in November 2017. A registered manager is a person who has registered with the CQC to manage the service. Like registered services, 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 home was managed by one of the company directors, who was not a registered nurse.

During our inspection we had some concerns about the fire safety at Oakleigh House Nursing Home. We shared our concerns with the London Fire and Planning Authority (LFEPA). The LFEPA is the regulator for fire safety in non-domestic premises, such as care homes. The LFEPA visited Oakleigh House Nursing Home on 2 July 2018 and issued Oakleigh House Nursing Home with an enforcement notice. In the response to this enforcement notice the registered provider decided to initiate the closure of Oakleigh House Nursing Home. We received written confirmation from the registered provider that on 20 July 2018 all people using the service had moved to alternative accommodation and that the home was planning to close.

We found that while people's risks had been assessed, guidance to mitigate such risks had not been followed by staff and outside clinical support was not always obtained to mitigate and respond and reduce such risk. Staffing deployed by the home did not always suitably meet the needs of the people who used the service, due to staff not always having the appropriate qualifications in providing nursing care to people. The service did not follow their own medicines procedure, by not always providing qualified registered nurses to administer medicines which meant safe medicines administration procedures were not complied with. The service did not always respond to and meet people's health and medical needs appropriately with people's health care and medical needs. The service did not always seek medical advice to ensure peoples medical needs were met holistically.

People's dietary needs had been met, however people had to wait long periods of time if they required assistance to eat and food was not always given to people at a suitable temperature. People's care was not always dignified. They had to wait long periods of time to be supported and on occasions were not always dressed appropriately. We saw that care record plans were in place; however, these had not been updated frequently to respond appropriately to people's changing needs. People were offered a limited choice of activities, tailored to their individual needs. Quality assurance systems were not always effective and the quality of care was not monitored effectively to ensure improvements could be made in a timely manner. The lack of consistent leadership and clinical guidance contributed to the shortfalls highlighted in this report.

Staff employed had been checked and vetted to ensure that they were suitable to work with people who used the service. Appropriate infection control procedures were adhered to, to minimise the risk of spreading infections.

New prospective people using the service or their relatives contributed to the pre-assessment process, however the records viewed lacked detail. Care workers had access to training and induction and had received supervisions. However, we found that not all staff had received up to date and current dementia training and most staff only had one planned supervision in 2018. Since our last inspection the service had started to redecorate the environment and the communal areas as well as the private areas of the home were now suitable to meet people's needs. The service worked within the principles of the Mental Capacity Act 2005 and appropriate Deprivation of Liberty Safeguards were sought to not deprive people who used the service of their liberty. However, we found that do not attempt to resuscitate orders were not stored appropriately.

People who used the service and relatives could contribute to the care provided. However, the information provided was not accessible to all people who used the service due to their communication needs.

People who used the service and relatives could voice concerns in relation to the treatment or care provided and most people were satisfied with the action taken by Oakleigh House Nursing Home. During this inspection none of the people were provided with end of live care.

The registered provider service was meeting the conditions of their registration. They were submitting notifications in line with legal requirements. People who used the service and relatives were given some opportunities to contribute to the running of the home.

We found five breaches of regulations and rated this service as inadequate. Normally, when services are rated inadequate they are placed into special measures. This did not happen and we did not take out more serious enforcement action, because the provider cancelled their registration to carry out the regulated activities and Oakleigh House Nursing Home closed on 20 July 2018. You can see what action we told the provider to take at the back of the full version of the report.

## 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. Risk to people was not always assessed and guidance to mitigate such risks had not been followed.

The service did not always deploy sufficient staff suitably qualified and skilled to meet the needs of people who used the service.

Medicines were not always managed safely and people did not always receive their medicines as intended by the prescriber.

The service ensured that staff employed were of good character and safe to work with vulnerable adults.

Appropriate measures had been taken to ensure people who used the service were protected by the prevention and control of infections.

### Is the service effective?

**Requires Improvement**

The service was not always effective. People's health care needs were not always fully met.

People who used the service were not always assisted appropriately with their nutrition.

Peoples needs were assessed, however the lack of detail within the pre-assessments led to some people's needs not fully been met.

Training, supervisions and appraisals were offered and provided to care workers, however, supervisions were not frequent and not all staff had received dementia specific training.

The environment was maintained and decorated and was conducive to people who used the service.

People who used the service were not deprived of their liberty and specific authorisations were sought in line with the principles of the Mental Capacity Act 2005 if required.

### Is the service caring?

**Requires Improvement**

The service was not always caring. People who used the service did not always receive dignified care and their needs were not always respected.

Information regarding the treatment or care had been made available to people who used the service, however this was not always accessible to all people who used the service.

## Is the service responsive?

**Requires Improvement**

The service was not always responsive. People's care records were available; however, these had not always been updated if needs had changed.

Regular tailor-made, stimulating and individual activities were not always offered to people who used the service.

People who used the service and relatives were mostly satisfied that there concerns and complaints were dealt with and responded to appropriately.

The service could provide end of life care, however none of the people currently living at the home received such care.

## Is the service well-led?

**Inadequate**

The service was not well-led. Quality assurance systems to monitor and assess the quality of care were not always robust and effective in addressing shortfalls appropriately.

The service lacked clear and consistent leadership and clinical guidance to ensure people's complex needs were fully met.

People who used the service, relatives and care workers mostly spoke positively about the new manager and the changes implemented.

People who used the service, relatives and care workers were involved in the service and their views were sought.

CareQuality Commission

# Oakleigh House 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. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection was prompted in part by a notification we received from the local authority that the registered provider did not provide qualified nursing staff over a 24-hour period.

This inspection took place on 21, 25 & 26 June 2018. Our visit on 21 June 2018 was unannounced. We gave the registered provider notice on 21 June 2018, that we will visit the service again on 25 & 26 June 2018.

On 21 June 2018 the inspection was carried out by one adult social care inspector and one expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses nursing and dementia care. On 25 & 26 June 2018 the inspection was carried out by one adult social care inspector.

Due to the change of the planned comprehensive inspection, the provider was not able to complete a Provider Information Return. This is information we require providers to send us at least once annually 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. Before the inspection we reviewed all the information we held. This included previous inspection reports and notifications the provider is required to send to us.

During our visit we spoke with the manager, the office administrator, three registered nurses (one permanently employed and two agency nurses), two senior care workers and two support workers. We spoke with four people who used the service, five relatives and one visiting friend.

We looked around the building including bedrooms and all the communal areas.

We examined care records for seven people using the service. We sampled medicines administration records including storage of controlled drugs, the recruitment, supervision and training records for seven staff and records in relation to quality assurance and management of the home.

Inadequate

# Is the service safe?

## Our findings

At our last comprehensive inspection in June 2017 we gave the service a rating of 'Requires Improvement' in this key question. This was because we found that sharp boxes in the medicines room were overfilled and had no lids. We also found sharp boxes in the laundry room, which could have been accessed by people who used the service and therefore could have led to the spread of blood born infections.

During our inspection in June 2018 we found that the registered provider had disposed of all sharp boxes and there was no longer a risk to people who used the service and care staff.

During our inspection in June 2017 we also found that the environment needed updating and highlighted several areas, which potentially could have led to people who used the service tripping on uneven floor covering. We also found that people with mobility problems, who liked to mobilise independently had insufficient adaptations such as grab rails provided on the first floor of the property.

During our inspection in June 2018 we saw that the service had replaced the carpets in the communal lounge and the hallways with lino flooring. We found the floor no longer to be uneven and the environment no longer presented a risk for people who used the service to trip or fall. We also saw that on the first-floor additional grab rails had been fitted, which ensured that people with mobility problems were able to independently mobilise safely.

We viewed various risk assessments for seven people who used the service. However, we found that risk assessments were not always detailed and guidance to minimise the risk was conflicting and not always followed by staff. For example, we saw in the 'Waterlow' pressure ulcer risk assessment for one person, which was done in February 2018, that the person was at high risk of developing pressure ulcers. However, we saw in the skin integrity assessment, which was carried out monthly, that the person was at medium risk of developing pressure ulcers.

We found in the Waterlow assessment of second person, that the person was at high risk of developing pressure ulcers. However, in the person's malnutrition assessment it was recorded that the person was a medium risk of developing pressure ulcers. At the time of our visit the person had a grade 2 pressure ulcer, which the person developed in December 2017. However, we found that no further review of the person's pressure ulcer had been carried until April 2018. We also did not see any evidence that the person had been referred for treatment to the local tissue viability nurse (TVN). We asked staff about the person and were advised that the pressure ulcer had healed.

A third person had a chronic wound. Their wound care plan stated, that the person's leg should be elevated, however whenever we saw the person, during the three days of our inspection visit, we only saw the person's leg elevated at one occasion. We discussed this with staff, who advised us that the person refused to elevate their leg and refused all treatment from the TVN and would remove the bandages.

We found records not always to be fully completed and accurate, which meant care workers did not have

current information to ensure people who used the service stayed safe. For example, the fluid chart for one person had not been fully completed and the total of fluids taken per day had not been reconciled since 18 June 2018. We found similar issues with the fluid chart of a second person.

During the time of our inspections, temperatures were very high. Therefore, correct recording and reconciliation of fluid records were important to ensure that people using the service were well hydrated to minimise the risk of dehydration.

We saw that the manager monitored and recorded accidents and incidents, however, we did not see evidence that action had been taken by the service to learn lessons from the accidents and incidents and make improvements to minimise the risk of similar accidents and incidents happening in the future. Care workers spoken with told us that accidents and incidents had not been discussed with the during supervisions or team meetings.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This inspection was triggered by information we received from the local safeguarding team advising us that Oakleigh House Nursing Home had not been providing nursing staff over a 24-hour period. We looked at the rotas from 23 April 2018 to 20 May 2018 and 4 June 2018 to 24 June 2018 and found that on 29 April 2018 no nurse was on duty during the afternoon, on 30 April 2018, 1 May 2018, 2 May 2018, 3 May 2018, 5 May 2018 and 8 June 2018 no nurse was on duty during the night shift on 8 May 2018 and 13 May 2018 no nurse was on duty during the day. This meant over a four-week period on eight occasions the home did not provide consecutive nursing care over a 24-hour period. Ten people living at Oakleigh House Nursing Home were assessed as being high dependent and requiring input from nursing staff to administer controlled drugs, intra muscular injections and other support to be carried out by a registered nurse. The lack of nursing staff led to one person being referred to hospital to have an intra-muscular injection administered, which would have been ideally administered at the home

We viewed the home's medicines procedure from January 2011, which stated that 'medicines are only to be administered by a registered nurse who will satisfy herself that she is competent to administer medicines'. However, the manager told us and records confirmed that medicines had been administered by senior care workers who had been trained by the manager.

We spoke with the manager about this and she advised us that she found it difficult to recruit permanent nursing staff. She also observed that registered nurses from the agency did not take part in caring duties and therefore decided registered nurses were not always required.

We also found that the manager had reduced the cover during the night from three staff to two staff. We spoke with staff about this who told us, that this had been very challenging, when they supported people using a hoist, which required two staff. The staff told us, that they had to leave people unsupervised on occasions due to the reduced numbers of staff on duty during the night.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The lack of qualified nursing staff had also an impact on the management of medicines. On the second day of our inspection we observed that no qualified nurse arrived to commence their shift at 08:00am. All people who used the service required support in the administration of medicines. By 10:45 none of the people who

used the service had received their medicines, which also included one person who was on a specific medicine, which had to be administered at a specific time. We asked the manager when people who used the service would receive their prescribed morning medicines. The manager told us that due to the lack of qualified nursing staff on duty, a trained care worker had been given the responsibility of administering medicines.  She was going to ask a senior care worker who had been trained by her to administer the medicines. Because of the late administration of medicines, the manager contacted the GP who advised the service not to administer the morning medicines to people who used the service. This meant none of the people living at Oakleigh House Nursing Home were administered their medicines during the morning of the 25 June 2018.

We also checked medicines administration records (MARs) for people who used the service and found gaps in the records. For example, one record showed that medicines for 10, 13, 15 and 19 June 2018 had been administered, but had not been signed for by the staff member administering the medicines. For another person the medicine administered at 18:00 on 20 June 2018 had not been signed for. For a third person the stock levels of one medicine should have been three, but the actual stock for this medicines in the persons cycle was five. This meant the person did not receive their medicines on two occasions.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We received varied feedback from people who used the service and relatives when we asked them if people living at Oakleigh House Nursing Home were safe. For example, one relative told us, "My relative is safe here and she would tell me if there is anything, she is happy here and well looked after." Another relative told us, "[Persons name] could not be anywhere better than here." Another relative told us, "We are not happy with the care. There are not enough staff. He has to wait a long time for help and we are not sure if he is safe."

Care workers spoken with told us that they would always speak with the manager and inform her if they saw anything of concern. They told us that they had received safeguarding training. Not all training records we viewed confirmed that staff had received safeguarding training. However, two of the staffing records we looked at were of staff who had recently started and one of the staffing records was for a member of staff who was not always in direct contact with people who used the service. We discussed this with the manager, who advised that they had been in contact with the local authority and were planning to arrange safeguarding training for staff.

Staff told us that the manager was responding to any safeguarding concerns raised with her. One care worker gave us an example of the manager investigating a concern raised with her, by visiting during the night to ascertain people who used the service received safe care and treatment.

The service followed safe recruitment procedures. Staffing records we viewed contained evidence of checks carried out by the service prior to offering employment. The checks viewed included two references, one of which was from the potential employee's previous employment, the right to work in the United Kingdom, proof of address and proof of identity as well as a recent police check. This ensured that staff employed were suitable to support vulnerable people.

The home employed a domestic cleaner, who was responsible for cleaning all areas at the home. We observed the cleaner using different colour coded cleaning equipment to prevent the spreading of infections. Care workers were observed wearing protective clothing such as gloves as well as uniforms. Hand disinfectants had been made available for people, care workers and visitors in communal areas and bathrooms. We found the home to be cleaner than during previous inspections, which had been confirmed

by one visitor who told us, "Since [manager name] started it is much cleaner here."

Requires Improvement

# Is the service effective?

## Our findings

At our last comprehensive inspection in June 2017 we gave the service a rating of 'Requires Improvement' in this key question. This was because we found that several maintenance issues had not been dealt with. For example, we found loose and dirty carpets, loose curtains in some of the people's rooms, missing light bulbs, a broken extractor fan in the kitchen and generally the home was in need for redecoration.

During our inspection in June 2018 we found that the service had replaced all carpets with easy to maintain and clean lino flooring. Curtains in people's rooms were hung correctly, missing light bulbs had been replaced, the extractor fan in the kitchen was in good working order and the communal area as well as vacant rooms had been redecorated.

People's health care needs were not always met. For example, one person was admitted to hospital due to the unavailability of staff qualified in the intra muscular injection of medicines. This had led to an unplanned stay at the hospital.

Another example, of a person losing almost 7kg from February 2018 to May 2018. However, we found no evidence of medical advice being sought to deal with the unexplained weight loss. The only information we found that the person had been visited by a Speech and language therapist (SALT) on 10 May 2018, who recommended a mashed diet. Unintentional loss of more than 5% of people's weight over 6 to 12 months is usually a cause for concern and should be referred to their GP for advice and action to be taken.

One person had been admitted with a chronic ulcer, the last pressure ulcer assessment was carried out on 21 April 2018, no further assessments had been carried out. We saw that the person did not wear a dressing on the leg ulcer and guidance of keeping the leg elevated had not been followed. Care workers told us that the person removes the dressing once applied and does not like to keep the leg elevated. We also saw that the person had been assessed as a high infection risk. However overall the only action taken by the home was to apply dressing to the wound and elevating the leg. No other action had been taken to minimise the pressure ulcer from developing further or minimise the infection risk.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's dietary requirements were not always met. We observed people waiting a long time if they required assistance to eat, due to staff being busy and supporting people. For example, we observed on one occasion during our lunch time observation, that one person had their food uncovered in front of them for 25 minutes, until a member of staff was available to support the person to eat. By this time the food was no longer warm and we observed staff making no attempt to reheat the food quickly.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We asked people who used the service and their relatives if they enjoyed the meals and if they had a choice. Everyone we spoke with told us that the food is "very good", "tasty" and "excellent". The home employed a permanent cook and all meals were freshly cooked and prepared. People were asked during the morning of their choice, which usually gave them two options. If people changed their mind when they were served their lunch, we observed that people were offered an alternative. Care staff assisted people to eat if required and the cook as well as the care staff were aware of people's dietary requirements, such as mashed or pureed food, the use of thickeners or people who had specific dietary needs due to health conditions.

We discussed with relatives if they felt that their relatives' needs were met at Oakleigh house Nursing Home. One relative told us, "I can tell you my husband's needs are met. I can't ask for more. I decide to shave him, but the staff are very good at the care they provide." Another relative told us, "I feel his needs are met. I was helping him when he was at home, some of the care he gets here, he would not have got at home."

Care workers told us that they had received training and supervisions during their time at Oakleigh House Nursing Home. However, they informed us since the new manager started in November 2017, the only training they had received was manual handling training. One care worker told us, "I had manual handling training recently and my last supervision about two month ago." Another care worker told us, "I received training in medicines administration from [mangers' name] and recently had manual handling training. I had my last supervision in April."

We viewed the training matrix for 2018 and saw that the service had planned the following training for all staff. For example, safeguarding 28 June 2018, falls prevention 24 July 2018, end of life care 23 August 2018 and pressure ulcer prevention 18 July 2018. We also viewed in staffing records that care workers who had been working at the home in 2017 had received training in food hygiene, nutrition and hydration and the use of food thickeners. Three care workers had received dignity training and had been appointed as dignity champions for the home. Several people using the service had dementia, but only a small number of staff had dementia training, we discussed this with the manager and made the following recommendation.

The manager and care workers spoken with told us that recently several new staff had commenced employment. We asked new care workers if they had received an induction and if they had commenced or completed the care certificate. The Care Certificate is an agreed set of standards that sets out the knowledge, skills and behaviours expected of specific job roles in the health and social care sectors. Care workers confirmed that they had received an induction, which lasted over four days and included online training as well as practical training. Staff records viewed confirmed that staff had an induction and completed or were in the process of completing the care certificate.

We noted that care workers received supervisions and appraisals, however most staff had only received one supervision in 2018. We discussed this with manager and made a recommendation.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act 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 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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions

on authorisations to deprive a person of their liberty were being met.

We saw that where people lacked capacity to make certain independent decisions the appropriate mental capacity assessments had been carried out in line with legislation. If people had been assessed as lacking capacity, the principles of the MCA had been followed and authorisations had been obtained from the local authority to ensure that the person was not unlawfully deprived of their liberty. We saw that all people had up to date DoLS authorisations and if they had expired or where not in place, we saw evidence that this had been followed up by the service.

Some people had Do Not Attempt Resuscitation (DNAR) orders in place. We found that all DNAR orders had been completed appropriately. However, we found that the DNAR orders were not easy to access in peoples care records and were kept in the middle of peoples care records as supposed at the beginning of the person's care records, to ensure it was easy to access if it ever was needed.

Requires Improvement

# Is the service caring?

## Our findings

At our last comprehensive inspection in June 2017 we gave the service a rating of 'Good' in this key question.

At this inspection we observed practice examples that people who used the service did not always receive dignified care and treatment. For example, the hand over sheet from the night shift on 24 June 2018 stated for one person, who had died two days prior to our inspection, "Due medication, well tolerated." This shows that staff completing the handover sheet was not aware that the person had deceased, did not know who the person was and must not have carried out welfare checks on the person during the night.

Another example of poor care was provided by one relative, who told us that their relative was sent to a hospital appointment in their underwear and a t-shirt. The relative discussed this with the manager, but received an unsatisfactory response and was made to feel as it was the person's fault and not the home's. This relative told us, "The care at Oakleigh House is very poor, there is never enough staff. My relative is left alone a lot of time. I have found my relative to be dirty and had to ask staff to give my relative a shower."

We also observed during the second day of our inspection a person waiting with their relative to go for a hospital appointment and asking staff to bring the person a cushion as he was very uncomfortable sitting in his wheelchair and was in pain. We sat with the person for 20 minutes until a member of staff arrived and brought a cushion for the person and supported him to sit more comfortably. We asked the member of staff why this took so long and the only response we got was "I couldn't find the cushion."

We also saw that 10 out of 17 people using the service spent most of time in bed in their room and observed little interaction with staff. We asked one person, who was not able to verbally communicate with us, but understood what we were asking. The person smiled during the start of our conversation, however, when we asked the person if she is well cared for, the persons facial expression completely changed and the person was no longer smiling and turned away.

We spent the majority of time during all three days of our inspection in the communal lounge of Oakleigh House Nursing Home and noticed on numerous occasions that people were left alone, with loud television sound in background, asking and shouting for care workers to support them or just have some company. We saw that staff came to support people and when they came were kind and friendly to people who used the service, but on at least three occasions people had to wait longer than 20 minutes until staff arrived to support them.

This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

While we observed some poor practices, we also observed care workers spending time with people, having a laugh with people and generally showing an interest in the person. Care workers spoken with were very positive about working at the home and told us that they enjoyed working with people and cared for them.

We spoke with people who used the service and relatives to get their view about the care provided at Oakleigh House Nursing Home. Overall, we received positive views about the care provided. One relative told us, "Staff are very kind and compassionate at their work and when attending to residents from my view." Another relative said, "The staff have shown compassion and respect to [person's name] and it is a very difficult job to do, I am very satisfied." Another relative told us, "We visit at different times of the day, she [relative] is always clean and well cared for."

The home arranged a relatives' and residents' meeting on 8 December 2017 during which planned renovation work, Christmas and menus were discussed. Minutes stated that relatives were happy that old bedsheets had been replaced and the manager informed relatives that they could contact and speak with her at any time. Relatives and people who used the service told us that they could speak with the manager if they needed anything changed or addressed. One relative said, "The manager listens and deals with anything I ask her." People who used the service told us that they had enough time to decide on what care they needed. However, many people were not able to communicate verbally, due to their medical and psychological condition or due to English not being their first language. We advised the manager that she must make information accessible for all people who used the service since The Accessible Information Standard had been introduced in July 2015. The Accessible Information Standard is a law which aims to make sure people with a disability or sensory loss are given information they can understand, and the communication support they need.

Requires Improvement

# Is the service responsive?

## Our findings

At our last comprehensive inspection in June 2017 we gave the service a rating of 'Requires Improvement' in this key question. We did not find sufficient evidence during our inspection in June 2018, that the service had taken appropriate corrective actions to improve the shortfalls found. For example, we found some care records lacked detail regarding the information required to provide individual personalised care. Care records contradicted information provided in the assessments carried out. For example, for one person we saw in the assessment that the person was at risk of developing pressure ulcers. However, the person's skin condition had not been reviewed since March 2015 and no clear guidance was provided in the person's care plan how the person skin condition should be monitored or cared for. Another person had lost a considerable amount of weight over the past few months. However, the person's care plan made no record to this weight loss and provided no guidance for staff on how to support the person to gain weight.

This was a continuing breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People who used the service were not able to tell us if they had a care plan or had been involved in the care planning, due to advanced dementia and other cognitive issues. Relatives, however, told us that they had been involved in the care planning. One relative said, "When [relative] moved in, we met and sat together to talk about the help which is needed." We found generally that care plans had been well structured and provided information about communication needs, lifestyles, skin integrity, environment, mental and physical health, continence, night-time support and any wishes in respect to illness or death. However, as stated above that records lacked detail and were not always regularly reviewed to respond to changing needs.

The home had an activity co-ordinator who had however been on long-term illness. During all three days of our inspection we did not observe any planned activities being offered or arranged for people who used the service. During the days of our inspections the TV was showing day time television shows in the background. On occasions care workers sat down with people, mostly during the afternoon and spoke with people. We saw activity records, which were not completed regularly and it was difficult for us to establish if regular activities had been offered to people.

We observed on several occasions, that some people had been left unattended in the communal lounge, for up to 25 minutes during one of our observations. Staff and relatives told us that activities such as sing-a-longs and garden activities had been offered, however we did not observe any evidence of this during our inspection. During all three days of our inspection the weather was hot and the doors to the garden was open. However, we did not see people accessing the large garden.

Most people who used the service had dementia, however we did not see evidence that dementia specific activities, such as reminiscences sessions or sensory sessions had been offered to people.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations

2014.

People who used the service told us that they were comfortable of raising any concerns with the manager. Most relatives confirmed that they would raise concerns with the manager and that they felt listened to. However, one relative we spoke with told us that they were not happy with the response they received from the manager regarding a concern they had raised. We spoke about this with the manager and were told, that she would go back to the complainant and discuss the concerns raised again.

Care workers told us that they would listen to any concerns raised with them and share it with the manager. They told us that they were confident that the manager would deal and resolve any concerns raised with her.

Since our last inspection the home had received one formal complaint from a relative. We saw that this complaint had been recorded and action had been taken to address the issue. However, as mentioned above the complainant had not been fully satisfied with the service's response to their complaint.

The home was also providing end of life support to people who used the service, if palliative care was required. However, at the time of our inspection none of the people living at Oakleigh House Nursing Home received end of life support.

Inadequate

## Is the service well-led?

# Our findings

At our last comprehensive inspection in June 2017 we gave the service a rating of 'Requires Improvement' in this key question. We did not see that robust quality assurance systems were effectively used. For example, shortfalls found during our inspection in June 2017 in relation to risk assessments and care planning had not been picked up and had therefore not been dealt with. Also, the lack of monitoring maintenance and the environment resulted in the property needing repair and uneven flooring presented a risk to people mobilising independently.

We did not find sufficient evidence during our inspection in June 2018, that the service had taken appropriate corrective actions to improve and implement effective and robust quality assurance systems. We found that quality assurance monitoring systems had not been completed or had not been effective. For example, medicines had not been audited since 14 April 2017. In addition to this care plans and risk assessments had not been audited since the last clinical lead left in April 2018. This contributed to the number of breaches in relation to medicines administration, risk management, care planning and the overall poor care or treatment we found during our inspection in June 2018.

This was a continuing breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We also found that there had been a lack of consistency in leadership at Oakleigh House Nursing Home. The registered manager had left in November 2017 and one of the company directors took over the interim management of Oakleigh House Nursing Home. The interim manager had no nursing qualifications and the home was unable to recruit a suitably qualified nurse who would oversee and manage the clinical leadership at Oakleigh House Nursing Home. The last clinical lead had left in April 2018. This lack of leadership impacted on the nursing care which had been provided and added to the poor nursing care people who used the service received at Oakleigh House Nursing Home.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We received mixed responses from people who used the service, relatives and care workers when we asked them about the new interim manager. Most of the people asked told us that the new manager had implemented changes for the better of the service. For example, one relative told us, "The manager is open and transparent and listens to what we have to say." Another relative told us, "There is always someone around to ask questions." Another relative told us, "Since [name of manager] started the food has improved, she is trying her best and the care has got better." One of the relatives spoken with was not as positive about the new manager and told us, "She does not listen to what we have to say and tells us why do you always complain."

Similarly, relatives and care workers gave us mixed responses regarding the new manager. One care worker said, "Since [name] started things have improved, she listens to what we have to say and will make

changes." When asked what changes the new manager had made following suggestions made by care workers. We were told, "We asked that we need new equipment to lift people and [name] bought it, this has made things easier." Another care worker however told us, "[Name] is quite ruthless and I don't feel she listens to what I have to say."

Care workers told us that the they had their last team meeting in May 2018, however, we were not able to view the minutes of this meeting. We were told by the manager, that she had not typed the minutes for this meeting yet. The team meeting before this was held on 3 November 2017. The discussions during this meeting were in respect to safeguarding and provision of care.

The last service users' and relatives' meeting was arranged for 8 December 2017 and maintenance, menu, Christmas party and home refurbishment was part of the agenda.

We saw that records were kept securely and could be located when needed. The registered provider was meeting the conditions of their registration and submitted statutory notifications in a timely manner. A statutory notification is information about important events which the service is required to send to the Commission by law.

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<br><br>Diagnostic and screening procedures<br><br>Treatment of disease, disorder or injury | Regulation 9 HSCA RA Regulations 2014 Person-centred care<br><br>The care and treatment of service users did not always meet their medical needs appropriately, by discussing the service users' treatment choices with a competent health care professional or other competent person to manage the service users care and treatment. Regulation 9 (1) (a) (b) (3) (c) (e).<br><br>Service users' nutritional needs did not always show regards for their well-being. Regulation 9 (3) (i).<br><br>Care plans did not always document how peoples assessed needs were met. Regulation 9 (3) (a) (b).<br><br>There was a lack of appropriate activities offered which would meet people's needs. Regulation 9 (1) (a) (b). |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br><br>Diagnostic and screening procedures<br><br>Treatment of disease, disorder or injury | Regulation 10 HSCA RA Regulations 2014 Dignity and respect<br><br>Services users were not treated with dignity and respect. Regulation 10 (1). |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br><br>Diagnostic and screening procedures | Regulation 12 HSCA RA Regulations 2014 Safe care and treatment<br><br>Care and treatment was not always provided in a safe way for service users. The register person |

| | |
|---|---|
| Treatment of disease, disorder or injury | did not ensure that risks to service users were assessed and not all reasonable steps were taken to mitigate any such risks. Regulation 12 (1) (2) (a) (b).<br><br>The registered person did not ensure the that service users that procedures for the management of medicines was safe and proper. Regulation 12 (1) (2) (g). |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br><br>Diagnostic and screening procedures<br><br>Treatment of disease, disorder or injury | Regulation 17 HSCA RA Regulations 2014 Good governance<br><br>The registered provider failed to implement effective systems to ensure the quality of care and safety was assessed and improvements were made to the quality of treatment or care people who used the service received. Regulation 17 (1) (2) (a) (b). |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br><br>Treatment of disease, disorder or injury | Regulation 18 HSCA RA Regulations 2014 Staffing<br><br>The registered person did not ensure that persons providing care or treatment to service users had the qualifications, competence, skills and experience to do so safely. Regulation 18 (1) (2). |