Quality Homes (Midlands) Limited

Oaks Court House

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?	**Requires Improvement**

Summary of findings

Overall summary

About the service
Oaks Court House is a residential care home providing personal care to 22 people aged 65 and over at the time of the inspection. Some of the people at Oaks Court are living with dementia. The service can support up to 41 people.

The home accommodates people across three floors. A passenger lift provides access to the first and second floor. At the time of the inspection the second floor of the home was unoccupied.

People's experience of using this service and what we found
People's experience of care had improved since the last inspection. Information relating to people's individual care needs was personalised and offered staff guidance on how to meet their needs. Further improvements were required to ensure risks to people's health and safety were assessed and clearly documented to reduce the risk of avoidable harm. Improvements were required to documentation within staff recruitment files, to ensure staff were safe to work with vulnerable people. Procedures relating to infection control were in place but were not always well established. People received their medicines as prescribed.

Improvements were still required to the oversight and governance of the home. While improvements had been made since the last inspection further work was required to establish effective auditing and governance systems to ensure people received safe effective care. People and staff reported positive changes at the home and feedback about the new management team was also positive. The manager and nominated individual told us they had focused on improving areas where people were most at risk and would now begin to develop robust systems used to monitor quality and drive improvement.

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 May 2020) and there were multiple breaches of regulation.

Following our last inspection we imposed a condition on the provider's registration to restrict new admissions to the home. We were mindful of the impact of 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 closely monitored the service to keep people safe and to hold the provider to account. 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 improvements had been made in some areas, however in other areas further

improvements were still required and the provider was still in breach of one regulation.

This service has been in Special Measures since 1 May 2020. During this inspection the provider demonstrated that improvements have been made. The service is no longer rated as inadequate overall or in any of the key questions. Therefore, this service is no longer in Special Measures.

Why we inspected
We carried out a comprehensive inspection of this service on 4 March 2020. Breaches of legal requirements were found. The provider completed an action plan after the last inspection to show what they would do and by when to improve safe care and treatment, good governance, dignity and respect, consent and person-centred care.

We undertook this focused inspection to check they had followed their action plan and to confirm they now met legal requirements. This report only covers our findings in relation to the Key Questions Safe and Well-led which contain requirements relating to safe care and treatment, dignity and respect and good governance.

The ratings from the previous comprehensive inspection for those key questions not looked at on this occasion were used in calculating the overall rating at this inspection. The overall rating for the service has changed from inadequate to requires improvement. This is based on the findings at this inspection.
You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Oaks Court House on our website at www.cqc.org.uk.

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 coronavirus and other infection outbreaks effectively.

Enforcement
We have identified a continued breach in relation to good governance 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 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.

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?

Requires Improvement

The service was not always well-led.

Details are in our well-Led findings below.

Oaks Court House

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.

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 carried out by two inspectors.

Service and service type
Oaks Court House is a 'care home'. People in care homes receive accommodation and nursing or personal care as a 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 manager registered with the Care Quality Commission. However, a manager had been recruited following the last inspection and told us they planned to register.

Notice of inspection
We gave the service notice of the inspection the day prior to our site visit. This was because the service is small and we wanted to be sure the manager would be at the home to speak with us.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We also sought feedback from the local authority and professionals who work with the service. 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 one person about their experience of care. We also spoke with two members of staff, the manager, the provider and the nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

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

After the inspection
We made phone calls to two further members of staff. We continued to seek clarification from the provider to validate evidence found. We requested further information from the manager which was provided.

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 the last inspection this key question was rated as inadequate. At this inspection this key question has now improved to requires improvement. This meant some aspects of the service were not always safe. There was a risk that people could be harmed.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong.

At our last inspection people had been placed at significant risk of harm. The provider had failed to ensure people were protected against the risk of fire. The management of risk to people's health and welfare was poor and the provider had failed to ensure adequate infection control practices were followed, which placed people at risk of cross infection. Staff struggled to meet people's needs in a timely way during busier times of the day. Accidents and incidents were not monitored to ensure the risk of reoccurrence could be reduced and lessons learnt where needed. The provider needed to improve their recruitment process with regards to how staff employment information was recorded.

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

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 12.

- Improvements had been made to the fabric of the building to address the risks identified at the last inspection. This included work to reduce the risk of fire. A new fire risk assessment was now in place and where areas for improvement had been identified these had been addressed.
- Care plans had been rewritten, were now personalised and contained details of people's individual needs. Although actions were being taken to minimise risks to people's health and safety, further improvements were required to ensure these were accurately recorded for each person and clearly reflective of people's current risks.
- For example, one person required regular repositioning to reduce the risk of sore skin. We found staff were supporting them appropriately and documenting times and dates of repositioning, however the person's care plan did not contain a risk management plan for their skin. This lack of clear guidance for staff may mean people receive inconsistent care.
- Where people experienced behaviours due to distress or anxieties staff were confident to approach them and understood how to safely support them.
- Incidents and accidents were now being recorded and appropriate action taken to reduce future risk. The manager had some oversight of events that had taken place in the home, however further improvements were required to ensure effective oversight of each incident and to identify patterns or trends and any learning.
- We observed staff supporting people with their mobility, this included the use of equipment, such as a

hoist. We saw transfers were completed safely and people were offered verbal reassurance throughout.

Systems and processes to safeguard people from the risk of abuse

● On the day of the inspection only one person was available to speak with us about their experience of life at Oaks Court. They told us they were well cared for by staff. We observed people receiving support from staff and saw they were confident to approach staff when they needed assistance or just to chat.

● Staff had received training in how to protect people from harm and knew how to escalate any concerns for people's safety. Where events had taken place the manager had notified CQC as required by law, however where additional information was required this had not always been provided in a timely way.

● Prior to the inspection we received feedback from other agencies which reflected they too had experienced delays when requesting information relating to safeguarding investigations. We discussed this with the manager who advised they had previously struggled to prioritise requests; however, they recognised the need to provide information promptly and would endeavour to do so in the future.

Staffing and recruitment

● At the last inspection we identified some concerns with staff recruitment files. At this inspection we found although audits had been carried out to identify any gaps in information, these had not yet all been completed. The manager told us they were aware of the need to take action and had already planned to address this in the days following the inspection.

● We observed staffing levels throughout the day and found people were supported by sufficient numbers of staff. People told us there were sometimes delays at night when they used the nurse call system to summon support, but overall spoke positively about their support.

● Staff we spoke with felt there were now enough staff on each shift to respond to people's need. One staff member said, "Seems to be more staff on the floor now…people do get lonely and need reassurance and someone to speak to, so there are more staff available now which is good."

Preventing and controlling infection

● Improvements had been made to the environment to improve the overall cleanliness of the home and reduce the risk of cross infection. This included the refurbishment of bathroom and toilet areas. We found areas used for washing and bathing were clean and equipment was in good working order. Some bathrooms were not in use, until refurbishment had taken place.

● We were somewhat assured that the provider was preventing visitors from catching and spreading infections. However, processes on arrival at the home did not seem well established. For example, one staff member did not appear to be familiar with having their temperature checked on arrival at the home.

● We were somewhat assured that the provider was accessing testing for people using the service and staff. The manager explained there had been some issues with the testing kits provided, and the logging of these for collection; however, in the days following the inspection the nominated individual confirmed testing for both residents and staff had taken place.

● We were not assured that the provider's infection prevention and control policy was up to date. There was some delay before the manager sent the policy to us and we found it did not contain current information and guidance relating to Covid-19.

● We were assured that the provider was meeting shielding and social distancing rules.

● We were assured that the provider was using PPE effectively and safely.

● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.

Using medicines safely

● People received their medicines as prescribed. Where people used medicines 'as required' staff were

aware of these and understood when and how to offer them to people. Staff were aware of people's health needs and understood how to manage their medicines in order to maintain their health, for example, diabetes.

● The manager assessed the competency of staff responsible for the administration of medicines to ensure their working practices were safe.

● Systems used for the management of medicines were safe and staff demonstrated a good knowledge of people's health needs and how their medicines were used to promote or maintain their health. Medicines were administered, stored and disposed of safely.

Requires Improvement

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 now improved to requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care;

At the last inspection the provider's poor governance did not ensure a continuous improvement in the quality and safety of care people received.

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

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17.

● Although significant improvements had been made since the last inspection there were still improvements required to documentation in care records and risk assessments as well as staff recruitment files. Improvements were required to ensure staff were given clear guidance to ensure people received safe, consistent care that met their needs.
● The was some oversight of individual incidents or events, however systems had not been established to identify any patterns or trends which would enable the provider to reduce the likelihood of incidents happening again.
● Policies and procedures, specifically relating to Covid-19 were not up to date. Although staff were following current guidance on the day of inspection, systems and processes did not appear well established.

● The manager and nominated individual were aware further improvements were required. They were working towards an action plan developed after the last inspection and told us they had focused on the areas which posed the most risk to people's safety and were now working on improving quality.

We found no evidence that people had been harmed however, systems were either not in place or robust enough to demonstrate effective governance of the service. 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.

The manager and nominated individual responded during and after the inspection. They sent copies of

audits they planned to implement and told us they were in the process of reviewing their infection control policy to ensure clear processes were established throughout the home.

At the last inspection the provider had failed to notify us of the death of a person. This was a breach of regulation 16 (Notification of death of a service user) of the Care Quality Commission (Registration) Regulations 2009.

At this inspection we found they were now submitting notifications relating to deaths and were no longer in breach of this regulation.

At the last inspection the provider had failed to notify us of incidents, including safeguarding allegations and police incidents. This was a breach of regulation 18 (Notification of other incidents) of the Care Quality Commission (Registration) Regulations 2009.

At this inspection we found the provider was now notifying us of incidents and was therefore no longer in breach of this regulation.

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

At the last inspected we found people were not always respected. People were referred to by their room number, rather than their name and were sometimes ignored by staff or not treated with dignity. This was a breach of regulation 10 (Dignity and respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of this regulation.

● We observed interactions between people and staff and saw staff used people's names and spoke to them in a polite and friendly manner. Staff were seen to be kneeling down to ensure they maintained eye contact with people who were sitting and offered reassuring touch and verbal encouragement when needed.
● People received prompt support when they needed it and staff were available to speak with people on a one to one basis, as well as support with personal care needs and meal times.
● We observed staff explaining people's health needs to them and gently reminding them about the importance of eating and drinking. Where people became distressed or anxious staff were available to respond and offer reassurance.

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 manager was aware of their responsibilities under the Duty of Candour. The Duty of Candour is a regulation which all providers must adhere to. Under the Duty of Candour, providers must be open and transparent, and it sets out specific guidelines' providers must follow if things go wrong with care and treatment.
● The nominated individual was open and honest with us about the failings identified at the last inspection. They told us they were working closely with the provider to try to raise standards at the service and improve people's experience of care.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others

● People and staff spoke positively about the changes that had taken place within the home. One person told us, "It's all been change, change, change, I never knew things could change so much in short space." A staff member commented, "The management team are easy to approach, they are visible. Any issues raised they act on them straight away."

● Staff spoke positively about the support they received. One staff member said, "I feel like I'm supported by the manager, they're always available and they listen. If I need to, I can speak to someone straight away."

● Examples were shared with us of how people had been involved in choosing paint colours for communal areas and were being supported to take part in activities that interested them, such as gardening.

● Opportunities to work in partnership with others were limited due to the Covid-19 pandemic, however the manager and staff team worked with other agencies such as healthcare professionals and social workers.

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	Regulation 17 HSCA RA Regulations 2014 Good governance Systems were either not in place or robust enough to demonstrate effective governance of the service. Regulation 17 (1), (2) (a, b, e, f).