Speciality Care (REIT Homes) Limited

Tall Oaks Care 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?	**Requires Improvement**

Summary of findings

Overall summary

About the service
Tall Oaks Care Home is a care home providing personal and nursing care to up to 55 people. The home was split between two floors, each with their own communal facilities, although downstairs had a larger space. The service provides support to older people who may be living with dementia or have a physical disability. At the time of our inspection there were 36 people using the service.

People's experience of using this service and what we found
Risks to people's health and wellbeing had not always been fully assessed and planned for. As there were a number of agency staff it was important they had access to the correct and current guidance about how to support people. There were also gaps in the recording of support some people were given so we could not be sure they were always receiving this support. Improvements were needed to the management of medicines, but the registered manager was already working on this. Systems in place to monitor the quality and safety of care had not always been effective, although the registered manager had also started putting better systems in place to improve this.

There was mixed feedback about staffing levels, and it was noted relatives and staff felt support was better when more permanent staff were working instead of agency staff. There was missing information in some staff recruitment files, although appropriate checks had been made to see what, if any, criminal convictions staff had. We were somewhat assured that the provider was using PPE effectively and safely. However, the home was clean and tidy and people and relatives told us they always thought it was without malodours. Lessons had not always been learned when things had gone wrong, but the registered manager was already taking steps to address this. There were no restrictions on visiting. People were protected from the risk of abuse by staff who understood their responsibilities and appropriate safeguarding referrals had been made.

The registered manager and management team were working hard to recruit more permanent staff. Relatives and staff felt able to go to the registered manager, if they needed to, despite the registered manager not working there permanently for very long. Staff told us they felt supported. The registered manager was aware of their duty of candour. The service worked in partnership with other organisations and professionals.

People were supported to have maximum choice and control of their lives and staff supported 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 CQC website at www.cqc.org.uk

Rating at last inspection
The last rating for this service was requires improvement (published 28 September 2022). The service remains rated requires improvement. This service has been rated requires improvement for the last four

consecutive inspections.

Why we inspected
This inspection was prompted by a review of the information we held about this service. The inspection was also prompted in part by notification of an incident following which a person using the service died. This incident is subject to further investigation by CQC as to whether any regulatory action should be taken. As a result, this inspection did not examine the circumstances of the incident. However, the information shared with CQC about the incident indicated potential concerns about the management of risk of supporting people appropriately with their health conditions. This inspection examined those risks.

As a result, we undertook a focused inspection to review the key questions of safe and well-led only. For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating. The overall rating for the service has remained requires improvement based on the findings of this inspection.

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 inspection reports and timeline' link for Tall Oaks Care Home on our website at www.cqc.org.uk.

Enforcement
We have identified breaches in relation to ensuring people received safe care and treatment, systems in place to monitor the safety and quality of care not always being effective and staff competency at this inspection.

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

Follow up
We will work alongside the provider and 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?

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below.

Tall Oaks Care 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.

Inspection team
The inspection was carried out by 1 inspector.

Service and service type
Tall Oaks Care 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. Tall Oaks Care 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.

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was a registered manager in post.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. 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 spoke with 3 people who used the service and 10 relatives. We spoke with 6 staff, including care staff, nurses, a regional support manager and registered manager. We made observations in communal area to find out people's experience of care. We also contacted an external professional after their details were shared with us by the home.

We reviewed 6 people's care plans and care records and multiple medicine records. We reviewed 3 staff files to check they were safely recruited and checked agency staff had profiles in place. We looked at management records, such as audits, policies and procedures and building safety records.

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
- The risk to people's health and wellbeing was not always safely managed.
- There had been a reliance on using agency staff to ensure there were enough staff to support people. However, agency staff may not know people as well as long term permanent staff. One relative said, "The permanent staff are very good. They know what's going on. The agency staff aren't great."
- Agency staff, or newly recruited staff, would rely on having access to correct, up to date care records and information from permanent staff. However, as there were omissions in people's care plans and records, this put people at risk of not always receiving the support they need.
- There was not always consistent recording of the support people were being given with their wounds. There were gaps in the recording of dressings being changed or they were recorded in different places. Care plans for wound care did not always match the most up to date treatment being given or advice from external health professionals. It was not always clear what support people needed, which left them at risk of receiving inappropriate care.
- The detail within people's care plans around their health conditions varied. We saw one very detailed plan, and one plan which lacked personalised detail. We also saw occasions for 1 person where their care plan was not followed which could put the person at risk.
- Some people remained in bed at all times, but it was not always clear why this was the case or what external professional input had been requested to support them to try to get out of bed.

The provider failed to follow ensure risks to people's health and wellbeing were sufficiently assessed, planned for a mitigated. This was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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.

Using medicines safely
● Improvements were needed to the way medicines were managed, but the registered manager had already started identifying and making improvements in this area.
● Some people were prescribed transdermal patches applied to their skin. Some patches can cause skin irritation or thinning of the skin if they are applied in the same place too often. Some records had gaps in as to where the patches had been applied, or had no records at all, so this left people at risk of having the patches applied in the same place which could harm them.
● Protocols were in place for 'when needed' medicines to help staff know when these could be administered. However, for 1 person, their guidance about when to administer constipation medicine was not clear and 1 other person had some missing guidance.

The provider needed to make improvements to medicines management. This was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Despite this, medicine stock levels generally matched records so we could be confident medicines were given as often as needed. Medicines were stored appropriately, and checks were made to ensure storage remained safe.

Staffing and recruitment
● There was mixed feedback about staffing levels, and it was noted by relatives they felt when regular staff were working, rather than agency staff, staff were more attentive.
● One person said, "No, I don't think [there are enough staff]. I've heard them say it themselves. The staff are always saying 'there's not enough of us'." Another person said, "I think there are enough staff and they're very good. They are very attentive." Another person told us they did not have to wait very long when they pressed their buzzer.
● A relative said, "It could always do with more staff. It's hard when someone wants the toilet. It's better than it was." Another relative said, "I sometimes feel they are very stretched. There is kindness, but they need more regular staff."
● Staff also gave mixed feedback; 1 felt staffing levels were fine as the staff numbers had increased recently whereas another felt there were not enough staff.
● We observed people did not have to wait a long time for support. There were periods of time when communal areas did not have staff in them, however these were not extended periods of time.
● Improvements were needed to staff recruitment. Staff did not always have a full employment history or evidence of identity checks available. Despite this, checks were made on staff references from previous employers and checks by the Disclosure and Barring Service (DBS). DBS checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.

Learning lessons when things go wrong
● Lessons had not always been learned when things had gone wrong, although the registered manager was working on making improvements to this.
● The local authority had visited the service and identified some areas for improvement and while attempts had been made to address these, this had not yet been fully effective, such as in relation to people's wound care.

Preventing and controlling infection

● We were somewhat assured that the provider was using PPE effectively and safely. We observed 1 staff member picked up a used urine bottle with no gloves or apron on, which could pose an infection control risk. However, we observed other staff wearing appropriate PPE.
● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.
● The home was clean and tidy, with no malodours. People and relatives told us they often visited at different times of the day, and they had never encountered any issues with the cleanliness of the home.
● We observed domestic staff cleaning throughout the day.

Visiting in care homes
There were no restrictions on visiting.

Systems and processes to safeguard people from the risk of abuse
● People were protected from the risk of abuse. People told us they felt safe.
● One person said, "They're [the staff] very good. They're so cheerful and do anything you want."
● Staff knew about different types of abuse, how to recognise potential abuse and understood their responsibilities to report concerns.
● Referrals were made to the local safeguarding authority as needed.

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 our last inspection we rated this key question requires improvement. The rating for this key question has remained 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

- This was the fourth consecutive inspection where the home has been rated as requires improvement overall. The provider had failed to make sufficient improvements. Therefore, people had been exposed to less than good care for a prolonged period of time and there had not always been continuous learning and improving of care.
- Systems in place to ensure people always received the correct wound care and that this was recorded were not always effective.
- Reviews or rewrites of people's care plans did not always identify omissions or areas to improve on, so they did not always contain enough detail or were not always up to date, which could leave people at risk.
- There was missing information about some staff members employment history and identity checks. These were important to have in place to ensure staff were safely recruited.
- The provider failed to keep records relating to competency checks on staff, to ensure their training had been effective and they could support people appropriately.
- The registered manager had started to identify and make improvements, but these were not yet fully in place or embedded.

The provider failed ensure systems in place were fully effective at monitoring and improving the care and support for people. This was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- There was a discrepancy between the maximum amount of people the home was registered to have living there and the maximum stated in the fire risk assessment. We have raised this with the provider to consider further.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- There was generally a positive culture, however this could be improved if there was a permanent team of staff in place to get to know people better so they could care in a more person-centred way.
- There was a need to use agency care staff and agency nursing staff to support the home. Despite agency staff being block booked, the use of agency staff meant sometimes they did not know people as well as

permanent staff. The registered manager and management team had recognised it was a priority to employ permanent staff and to reduce the use of agency. The use of agency staff had already reduced since the registered manager had started, and work was ongoing.

● There was mixed feedback about how easily people and relatives could communicate with staff who had English as a second language. Most felt they could communicate well enough, but some did feel due to a difference in language they struggled to make their needs known and be understood. The registered manager explained they checked staff could communicate well enough in English and took action should it be noticed improvements were needed.

● Relatives and staff felt able to go to the registered manager, if they needed to, despite the registered manager not working there permanently for very long.

● One relative said, "[Registered manager] is new and only just started. We don't really know them yet. [Registered manager] has put a message on social media that we can go in to see them. I'd go to [registered manager], if I needed to raise a concern." Another relative said, "I feel at ease knowing [my relative] is here." Another relative commented, "When I've raised things, [registered manager] has been very on the ball."

● Staff told us they felt supported. One staff member said, "I'm well supported by the nurses, which makes our job easier, they'll help us with anything. We're happy [the registered manager] is here. We can go to them. [Registered manager] does ask us, they do listen." Another staff member told us, "[Registered manager] has made clear to everyone, their door is always open. Not many managers do that."

● People were supported to practise their faith, should they choose to. We were told of a church service people could attend.

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 registered manager was aware of their duty of candour.

● Relatives told us they had been informed if something had happened and had received an apology.

● Notifications were submitted to us, and the previous inspection rating was displayed, as required.

Working in partnership with others

● The service worked in partnership with other organisations and professionals.

● The local authority had developed an action plan for the provider to work to and the registered manager had commenced work in addressing actions.

● Multiple other professionals were involved in supporting people. For example, if someone was nearing the end of their life, a local palliative care charity was often involved.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider failed to follow ensure risks to people's health and wellbeing were sufficiently assessed, planned for a mitigated. The provider needed to make improvements to medicines management.

The enforcement action we took:

Warning notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed ensure systems in place were fully effective at monitoring and improving the care and support for people.

The enforcement action we took:

Warning notice