Red Oaks Healthcare Limited

# Red Oaks Care Community

## Inspection report

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Date of inspection visit:
18 August 2020

Date of publication:
15 October 2020

## Ratings

| | |
|---|---|
| Overall rating for this service | Requires Improvement |

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

# Summary of findings

## Overall summary

About the service
Red Oaks Care Community is a care home providing personal and nursing care to 23 people aged 65 and over at the time of the inspection, including those living with dementia. The service can support up to 40 people. Red Oaks Care Community is purpose built. It is split over two floors with communal areas on each floor.

People's experience of using this service and what we found
People were at risk of avoidable harm because their individual risks were not always recorded accurately, regularly monitored, or well managed.

Risks associated with the environment had not always been safely managed.

People were not always protected from the risk of avoidable harm or abuse because the systems and processes in place to safeguard people were not always effective. Lessons had not been learnt when things went wrong.

There was no registered manager in post and there was ineffective oversight of the service by the provider. Management of the service had been inconsistent and the provider's governance processes were not effective. Quality assurance systems and processes failed to identify concerns relating to safe care. Where issues had been identified the service did not act in a timely manner to address them.

Medicines were not always managed safely. We could not be sure people always received their medicines as prescribed. The provider's medicines audit system was not effective.

There were not always enough staff to give people the care and support they needed. The provider had not always staffed the service in-line with people's assessed dependency levels.

Infection prevention and control procedures did not always follow Government guidance and requirements. People were not always supported to maintain social distancing and the provider did not always follow guidance regarding safe admissions from hospital.

The provider's quality audits were ineffective. They had not identified the issues we found during the inspection; including health and safety issues and staffing levels.

Staff said they felt able to approach the manager with any comments or concerns. They felt morale at the home was improving. Relatives felt their loved ones receive good care.

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 requires improvement (published 19 July 2019) and there were multiple breaches of regulations. The provider completed an action plan after the last inspection to show what they would do and by when to improve.

At this inspection enough improvement had not been made and the provider was still in breach of regulations. This service has been rated requires improvement for the last three consecutive inspections. We will arrange to meet with the provider to discuss how they will make the improvements to the service.

Why we inspected
We carried out an unannounced comprehensive inspection of this service on 22 and 23 May 2019. 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 good governance and staffing.

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 those requirements.

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 remains 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 Red Oaks Care Community on our website at www.cqc.org.uk.

We found evidence that the provider needs to make improvements. Please see the safe and well-led sections of this full report. You can see what action we have asked the provider to take at the end of this full report.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to monitor the service to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to the safety of the care people receive, staffing and the governance arrangements the provider has in place to monitor the safety and effectiveness of this service.

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

Follow up
We will request an action plan for the provider to understand what they will do to improve the standards of quality and safety. We will work with the 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?**

Inadequate

The service was not always well-led.

Details are in our well-led findings below.

# Red Oaks Care Community

**Detailed findings**

## Background to this inspection

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

Inspection team
Inspection was carried out by two inspectors and a specialist nurse advisor.

Service and service type
Red Oaks Care Community 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 CQC. A manager had recently started working at the service and they told us they would apply to be registered but had not done so at the time of the inspection. When a manager is registered with CQC it means they, and the provider, are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
We gave the service 24 hours' notice of the inspection. This was because we needed to understand the Covid-19 infection control precautions the provider had in place, and to ensure the inspectors understood the current status of any potential infection risks.

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. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections. We used all of this information to plan our inspection.

During the inspection
We spoke with three people who used the service, nurse, team leader, two care workers and domestic staff. We also spoke with the manager and a manager from one the provider's other location. The manager from other location was providing support to the manager at Red Oaks Care Community. We observed the care being provided and reviewed a range of records. This included five people's care records and multiple medication records. We looked at four staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We received feedback from seven relatives about their experience of the care provided to their loved ones and spoke with two care workers. We reviewed variety of records relating to management of the service including the provider's policies and procedures, staff rotas, dependency tools, audits, training data, quality assurance records and risk assessments.

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 Requires Improvement. At this inspection this key question has remained the same. 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.

Staffing and recruitment
At the last two inspection there was a breach of Regulation 18 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This related to the risk of ineffective care because staff were not always trained or supported to perform their role. At this inspection, we found some improvements had been made to staff training which has meant they have met this part of the regulation.

● People were not always supported by enough staff to meet their care needs. The provider used a dependency assessment tool, but this did not effectively consider the actual needs of people. This demonstrated the provider had not always obtained a clear understanding of people's needs before deciding on the numbers of staff to deploy.
● We reviewed staff rotas for the period 20 July 2020 to 16 August 2020. Rota records showed staffing numbers fell below the provider's own identified requirements on 28 shifts. That meant there was not enough staff on those occasions to ensure people's needs were fully met.
● People did not always receive care promptly. Staff did not always respond promptly when people called for assistance. One person, who was being cared for in bed, was heard calling for help for over ten minutes before receiving attention from staff.
● A relative told us they felt there was not always enough staff. They said, "The staff are always busy, just before the lockdown they were under capacity, so the staff levels were ok. I don't know if the numbers have changed since lockdown. It would be nice if they could continue like this as when the home is full the carers are run off their feet."
● Another relative told us "There isn't enough staff on shift. Before lockdown I always had to go find staff - staff are very good, but it would be good if there were more staff on each floor."

The failure to deploy sufficient numbers of suitably qualified, competent, skilled and experienced staff was a continued breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People were usually supported by staff they knew. The provider had an effective recruitment policy and procedure in place. Staff received an induction into their role, which included the provider's mandatory training. Training staff had completed included; safeguarding adult, dementia awareness, end of life and falls prevention.

Assessing risk, safety monitoring and management
● People were at risk of harm from hot water outlets. Hot water temperature from one shower was found to

reach potentially scalding temperatures. The provider had not taken effective action to monitor and reduce the risk of scalding.

● People were not always effectively protected from the risk of fire. Essential fire safety work, as identified in the provider's fire risk assessment, had not all been completed. The provider had known about a faulty fire detector since at least December 2019, but had not taken effective action to remedy that fault. We discussed this with the manager and notified the Local Fire and Rescue Service. The provider told us they would make arrangements to rectify the faulty fire detector.

● People were not always protected from the risk of potential Legionella infection. The provider did not have an appropriate Legionella risk assessment in place. Infrequently used water outlets were not always regularly flushed, and cold water outlets were above the maximum safe temperatures; which could lead to build up of Legionella bacteria harmful to people.

● People's risk assessments lacked important detail and staff were not always informed how to keep people safe. For example, risk assessments for people who required assisted transfers lacked details about the size or type of sling to use. This put people at risk of being transferred in an unsafe way.

● Risk assessments for people who were at risk of choking lacked details. For example, a risk assessment showed that a suction machine was to be used in case the person choked, however the location of the suction machine was not identified. This meant people were at increased risk of choking due to a delay in using the suction machine.

● People were not effectively protected from risks associated with their health conditions. Care plans for the management of pressure sores for people with limited mobility lacked details. Records showed that a person was not always supported to have their position changed to reduce skin deterioration. This put the person at risk of developing pressure sores.

The failure to assess, monitor and mitigate risks or to ensure the safety of the premises and equipment was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection

● The provider did not always follow national guidance in relation to infection prevention and control for the Covid-19 pandemic. The provider had not introduced procedures to detect and control the spread of infection during the Covid-19. At the time the inspection was carried out, national guidance was for people to remain two meters apart wherever possible. We observed breakfast time where four people were sat at one table next to each other. There was enough space for the activity to be completed whilst observing social distancing. This put people and staff at risk.

● People were not always supported to isolate if they had recently been discharged from hospital to reduce the risk of transmitting infection.

● Individual Covid-19 risk assessments had not been carried out on each person to identify their individual susceptibilities. The provider had not taken additional measures to protect people with additional health care needs which put them in the very high-risk group.

● Risks to people who did not have the capacity to consent to Covid-19 testing had not been assessed or mitigated.

● During the inspection visit we noticed personal toiletry items in the communal bathroom, which meant there had been a risk of the spread of infection as they could have been used by other people.

The failure to assessing the risk of, and preventing, detecting and controlling the spread of, infections was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People lived in an environment which appeared clean. People's rooms and communal areas were generally clean and there were no unpleasant odours.
● Throughout the inspection we observed staff carrying out suitable infection control measures. For example, all staff wore face masks due to the Covid-19 pandemic. The manager said the service had a good supply of personal protective equipment, and future supply lines were satisfactory.

Learning lessons when things go wrong
● The provider's accident and incident reports had not always clearly described details of what happened. Details of any actions the provider had taken, as a result of the incident, were not always recorded.
● The provider's accidents and incident forms were not always reviewed by the manager. Opportunities had been missed to pick up on emerging themes or risks. For example, one person who lacked capacity had left the service unattended and unnoticed on 29 July 2020. Measures to reduce the risk of this person leaving the service again had been put in place, however were ineffective. The same person left the service unattended and unwitnessed again on 1 August 2020 which resulted in hospital treatment. This meant action was not always taken to prevent recurrence.
● The provider had not always taken appropriate action to ensure lessons were learned from incidents, and improvements made. For example, the provider had received several recommendations for improvement following an external audit; these had not been fully addressed or actioned by the provider.

Systems and processes to safeguard people from the risk of abuse
● Staff understood how to safeguard people from abuse. Staff had received safeguarding training, were aware of safeguarding procedures, and knew how to use them.
● Staff were aware of their responsibilities to protect people from abuse. Staff were aware of whistleblowing and how to raise concerns with the registered manager and outside agencies. Staff told us they felt able to raise concerns with the manager.

Using medicines safely
● The medicines trolley was clean and well organised. 'As required' medication protocols had been updated and provided enough information for staff to ensure people got their medicine when they needed it. We saw staff being patient and kind during medication administration
● Medicines were stored safely at the right temperature.
● Medicines that are controlled drugs were managed appropriately

Inadequate

# Is the service well-led?

## Our findings

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

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

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

At the last inspection, there was a lack of proper oversight of the service, policies were not followed and auditing and checking processes were not sufficiently robust. 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, Good Governance.

● There were repeated and significant shortfalls in governance and leadership across the service. Breaches identified at the last inspection had not been adequately addressed. The provider's action plan had not been effective in resolving the issues previously identified.
● Necessary management action had not been taken to ensure good care was being provided. The service had been consistently rated requires improvement for the last three inspections and the service had been without a manager registered with CQC since October 2018.
● Frequent changes of manager had a potentially destabilising effect on the service. The care home had four different managers over the past year. The lack of management stability, combined with ineffective governance activity by the provider, resulted in a lack of improvement in the quality of care.
● The provider's safety risk assessments were ineffective. For example, we reviewed the fire risk assessment which had been completed in March 2020. The risk assessment was not up to date, accurate, properly analysed, or reviewed by a person with the appropriate skills and qualifications.
● The provider's health and safety monitoring was inadequate, and the provider had not always taken swift action to ensure property defects were rectified.
● The provider could not ensure the correct deployment of skilled staff due to not having an adequate dependency tool in place. The manager told us they review dependency tool on a weekly basis, however the tool had not reflected people's changing care needs.

The failure to operate effective systems to assess, monitor and improve the service and to maintain an accurate, complete record in respect of each service user was a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff had regular handovers between shifts. Good handovers helped ensure good communication between the team and helped maintain consistency of care.

Continuous learning and improving care

At the last inspection there was a continued breach of Regulation 17 (Good Governance) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This related to the provider's failure to ensure that people were protected from risks associated with ineffective monitoring and inconsistent record keeping.
Not enough improvement had been made at this inspection and the provider was still in breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People remained at risk of harm as the provider's systems were inadequate. Systems and processes were not operated effectively to ensure the service was monitored for quality and safety. The provider's processes had not identified all the shortfalls we found with medicines systems, health and safety and staffing. Where shortfalls had been identified by the provider, action had not always been taken to resolve them.
● Medicines were not always managed safely. The provider's internal medicines checks and audits were ineffective. Medication audits had not always been dated and signed for. We were unable to determine correct amount of medication in stock. This meant we were unable to establish if people received all their prescribed medication. The provider identified medication recording errors, however no action had been taken to investigate these.
● Staff received training in medicines management and had their competency regularly assessed. However, we were concerned the systems in place were poor and did not provide assurance that staff had the knowledge and skills they needed to administer people's medicines safely.
● Incidents were not always reviewed by the manager. Action was not taken to analyse incidents and put measures in place to reduce risks.
● We found there was no system in place for safeguarding incidents to be appropriately recorded, reported and investigated. This put people at continued risk of harm as they were not reviewed or known to external agencies.
● Staff who were involved in incidents had not received any debrief and there had been no evidence to show lessons were shared with others to promote learning.

The failure to ensure that people were protected from risks associated with ineffective monitoring and inconsistent record keeping was a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong
● The provider had not always reported safeguarding incidents to the local authority safeguarding team and CQC. The provider is legally required to notify CQC when certain events have happened. We checked and saw these were not always submitted.

As notifiable incidents had not always been sent in to the CQC this is a breach of regulation 18 of the (Registration) Regulations 2009.

● Communication with relatives when a specific incident occurred was transparent, outcomes of the investigations were not always clearly detailed. In most cases, the person or their representative had been given the opportunity to liaise with the manager about the incident.

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

outcomes for people

● People and relatives were satisfied with the quality of care they received from the service. One relative told us, "Very happy, the staff are efficient and kind." Another person said" They [staff] are good to me, I am not a mixer and I like my own company."

● Staff told us they feel supported by the manager and received supervision and appraisal of their work. Staff said the manager was approachable and available when they needed to speak with them.

● The overall atmosphere at the home was warm and welcoming.

Engaging and involving people using the service, the public and staff

● One relative told us "I have always felt able to discuss [person's] care with staff and managers and to raise any new concerns with them. They have taken appropriate action. I have been asked to read through [person's] care plan on a few occasions and had a recent phone call to briefly discuss it."

● People received opportunities to share their views about the service during monthly "reflections" meetings.

● The provider had kept in touch with families throughout the last few months, when visitors were not allowed in to prevent transmission of Covid-19. Regular e-mails and telephone calls were arranged, so relatives were kept up to date about their loved one's progress.

● Staff told us they worked as a team and were supported by the management team as required.

Working in partnership with others

● Manager and staff team were working with health professionals such as tissue viability nurses, to ensure that people received the support they needed.

● Further development of working in partnership with key organisations including safeguarding teams was required to ensure good outcomes for people.

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>Treatment of disease, disorder or injury | Regulation 18 Registration Regulations 2009 Notifications of other incidents<br><br>The provider failed to notify the Commission of safeguarding events that affected people living at the service |

| 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 provider failed to deploy sufficient number of staff to ensure service users had the correct level of support they were assessed as needing. |

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 | Regulation 12 HSCA RA Regulations 2014 Safe care and treatment |
| Treatment of disease, disorder or injury | The provider failed assess the risk to health and safety of people who use the service and did not do all that was reasonably practicable to mitigate any such risks The provider failed to ensure proper and safe management of medicines.<br>The provider failed to assess the risk of, and preventing, detecting and controlling the spread of infections, including those that are health associated. |

**The enforcement action we took:**

We issued a Warning notice

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 17 HSCA RA Regulations 2014 Good governance |
| Treatment of disease, disorder or injury | The provider failed to assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity. |

**The enforcement action we took:**

We issued a Warning notice