Park House (Exeter) Limited

Oak Wood House

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Oak Wood House is a residential care home providing personal care to 18 people aged 65 and over at the time of the inspection. The service can support up to 18 people. Oak Wood House is a large premises, located on the edge of a rural village, set over two floors accessed by a lift, ramp and stair lift.

People's experience of using this service and what we found
Although peoples' and relatives' feedback was predominantly positive, we found people were not receiving timely, person centred care that met their needs and kept them safe.

People were not safe at Oak Wood House. There was not an effective system to identify and manage risks associated with people's care. Risks were identified and recorded in people's care plans but actions for staff to take to keep people safe were not recorded meaning that people's risks were not well managed. For example, risks relating to falls, moving and handling, behaviours which could be challenging for others and skin pressure damage and integrity.

Staff did not demonstrate a good knowledge of how to protect people from harm. They did not know how to manage behaviours that could be challenging, or monitor or report unexplained bruises appropriately to keep people safe.

Health needs were difficult to follow up within the computer system in relation to monitoring and outcomes. This included when health professionals had been contacted and actions taken. For example, in relation to identifying deterioration in health, reduction in mobility, infection and medication reviews. However, this was not consistent.

Although there was a cleaning regime in place to support good infection prevention and control, lack of good continence management had resulted in a large number of continence accidents requiring additional deep cleaning. This meant that some carpets and furniture was very soiled and odorous and did not promote good infection prevention practice. Environmental and health and safety audits were carried out regularly, but they had not picked up these issues. The home was otherwise very clean and there were no odours permeating throughout the communal spaces.

People were not supported by enough staff who were trained to meet their needs. Staff knew people well and were caring, however their interactions with people were task related. However, there were not enough staff to meet people's needs in a timely way, engage with people meaningfully or provide individualised care and support with person centred care. Staff did not all understand person centred care and were not supported by the provider and seniors team to promote this culture.

People were able to attend activities in the week with the activities co-ordinator but there were minimal activities at the weekend. There were no activity audits to ensure individuals were able to engage regularly

with each other, and staff, or ensure they could pursue their interests.

There were no robust audit systems in place to identify any areas which required improvement and ensure action was taken to develop practice if needed. Audits were completed but did not translate to actions being taken or monitored in practice. Most of the concerns we raised during this inspection had been raised by staff already with no actions taken. There was no documentation of provider insight or oversight.

People were not involved in decision making about their care or able to make meaningful decisions and choices. For example, about when to rise and go to bed or where to spend their time due to the staff workload and routine. People and relatives were given opportunities to give feedback on their care and told us they felt comfortable in doing so but the survey results had not addressed all their comments.

People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests in practice although; the policies and systems in the service supported this practice.

People's medicines were administered safely in the way prescribed for them. However, we found areas for improvement for some aspects of the way medicines were managed. The provider discussed with us their plans to make the necessary improvements.

Mealtimes were a social event in a pleasant setting and people were able to enjoy food they liked in a way that met their needs.

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 the service under the previous provider Oak House (Exeter) Ltd was rated Good, published on 4 March 2020. This service was registered with us on 21 June 2021 and this is the first inspection.

Why we inspected

The inspection was prompted in part due to concerns received about staffing levels, cleanliness, continence management, eating and drinking, medicines, skin pressure care and skin integrity management and leadership. A decision was made for us to inspect and examine those risks.

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

We have found evidence that the provider needs to make improvements. Please see the safe, effective, caring, responsive and well led sections 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 discharge our regulatory enforcement functions required 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 safeguarding, risk management, person centred care, dignity and privacy, choice and consent, staffing levels, training and competency, premises and good governance.

We also made two recommendations in relation to meeting peoples' social and leisure needs and improving dementia care.

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

Follow up
We will meet with the provider and request an action plan for 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.

Special Measures:
The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe. And there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it. And it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

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.

Details are in our safe findings below.

Is the service effective?

Inadequate

The service was not effective.

Details are in our effective findings below.

Is the service caring?

Inadequate

The service was not caring.

Details are in our caring findings below.

Is the service responsive?

Inadequate

The service was not responsive.

Details are in our responsive findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-Led findings below.

Oak Wood 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. A third inspector from the medicines team attended on 5 October 2021. An Expert by Experience also carried out telephone calls to some relatives on 8 October 2021. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of service.

Service and service type
Oak Wood 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. The provider is legally responsible for how the service is run and for the quality and safety of the care provided. The previous registered manager had recently left the service in September 2021.

Notice of inspection
This inspection was unannounced at 6am on the first day.

What we did before 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, including the safeguarding team and community nurses. 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 looked at the response to the concerns from the provider. 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 five people who used the service and one relative about their experience of the care provided. We spoke with members of staff including the provider, acting manager, two senior care workers, care workers, two housekeepers, the chef and kitchen assistant, activity co-ordinator and administration assistant. We also spoke with five relatives on the telephone.

We reviewed a range of records. This included seven 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, including policies and procedures were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data, handover and quality assurance records.

Inadequate

Is the service safe?

Our findings

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

This is the first inspection for this newly registered service. This key question has been rated Inadequate. This meant people were not safe and were at risk of avoidable harm.

Systems and processes to safeguard people from the risk of abuse

- Although people and relatives told us people were safe at Oak Wood House, commenting "I have never worried about safety. I have not had a reason to. They (staff) keep them safe and the place is secure, there is a door bell, you can't just walk in" and " They use the COVID-19 restrictions; we did the test, The place is clean and tidy." However, we found there were not effective systems or procedures in place to protect people from the risk of abuse and harm.
- Staff had not appropriately raised safeguarding issues with the correct authorities, notified us or completed thorough investigations, despite completing safeguarding training online. One person had a body map with various entries of unexplained bruising and a skin cut. There was no follow up or investigation into the bruising. We found this coincided with incidents of behaviour relating to incontinence episodes which could be challenging including physical aggression towards staff. One staff member said, "Yes his bruising on his arms was quite bad" but could not tell us what had happened about it. Staff could not tell us what people's skin integrity was on the days of our inspection or show us where this was recorded despite there being body maps for some people showing bruises, red areas, wounds or soreness.
- A safeguarding notification had not been made in relation to an allegation of poor support with assisting people to eat or about a person being stuck in the lift for nearly an hour.

Due to poor safeguarding systems, processes and practices at the service, people were placed at risk of harm. This is a breach of regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management

- Risks were identified, and assessments completed but there were not always actions recorded to show staff how to keep people safe. The acting manager was unable to explain how risks were being mitigated and said the previous manager did that. For example, in relation to the risk of falls. Care plans stated that people should be regularly checked but there was no evidence of this happening. Although there was a monthly falls audit completed, including conclusions, issues were not identified, and actions were not taken in practice such as assessing staffing levels.
- There were no bed rail risk assessments despite some people using them. The provider said there had been bed rail assessments up until June 2021.
- On the first day of the inspection, it took 30 minutes for the us and acting manager, who was on call, to gain access to the home. The two staff on duty were busy in one room, leaving the rest of the premises unattended. We toured the home and found one person lying flat with their head having fallen off the pillows. They had slid down the bed and their legs were crossed in the bed rails. This was a serious risk of potential injury to the trapped person. We asked the provider to take some immediate actions to mitigate

such serious risks to peoples' safety. The person said, "This bed is not right, it's terrible." They could not reach their call-bell, so we rang it, but it took another hour for them to be supported to sit up. Another two people were shouting out for assistance to move, one person lying flat who also could not use their call bell, saying "Help me I'm stuck". Another person said, "I'm sliding off the chair, I'll be on the floor in a minute." There were no call bell audits or care plans stating how to monitor people who could not use a call bell.

● Skin pressure area care was poor and although it was easy to see daily record entries for people being re-positioned at night, it was not easy to monitor re-positioning for people during the day as entries were lost within the daily records. One person's care plan stated, "Her chair should be adjusted slightly on a regular basis to assist with pressure relief function." We saw no entries that this was done. This person often had moisture lesions which the body map said they had but we could not see what the current state of their skin was to monitor if care was effective. However, we did see that a referral had been made to an occupational therapist to assess their moving and handling. People did have pressure relieving mattresses for when they were in bed, but we did not see records showing what settings or how they were checked.

● One person slept in the lounge all night and required a pressure relieving cushion. This was on the chair next to them and the person kept asking for it. We had to ask staff to put it under them. After an hour we had to ask staff again until it was addressed.

● One person was at risk of constipation exacerbated by their medication. This was not monitored and there was no oversight of bowel management.

Learning lessons when things go wrong

● The provider had not ensured lessons were learnt and actions taken to address any issues. Staff meetings showed that concerns had been raised about staffing levels previously and all staff told us they had raised the issues. The housekeepers had also raised and recorded that they were undertaking additional deep cleaning, sometimes without appropriate equipment to clean effectively.

People's risks were not well managed to keep them safe. This is a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Some individual risk assessments were appropriate and were being followed such as one to enable a person to smoke safely.

Staffing and recruitment

● Staffing levels were not adequate to ensure people's needs were met in a timely way or to keep people safe. There were no staff allocated to manage people at high risk of falls in the communal lounge. The provider told us staff were allocated to the lounge, but this was not happening. One person had spent the previous night in the lounge on our first day of inspection, and they were unattended in the lounge with two other people at high risk of falls with no access to a call bell for nearly two hours. Records of the times people actually went to bed showed they were often in the lounge at 6am and up until 11pm, when the two night staff were unable to supervise the lounge because they were supporting others in bedrooms and other areas.

● 14 people required assistance with continence management throughout the day. Rotas showed four care workers in the day, supported by a senior care worker who had other tasks to complete. There was no way of monitoring this support as daily record entries were unrelated to the time an action was completed. Staff told us they relied on people using continence aids, there were multiple records showing housekeeping staff having to carry out additional deep cleaning of carpets and furniture due to incontinence. Staff told us they did not have time to support people to access the toilet enough.

● On the second day of the inspection staff said people should have been supported with continence around 10.30am but they had not been able to until 12.00pm. This meant some people had not been

supported to the toilet since 6, 7 and 8am when they had received personal care. One staff member said, "If we are late with toileting people are wet."
● Ten people required two care workers for all care. This meant that if two people were receiving personal care in their rooms and the senior care worker was doing the medicines round or busy, there were no care workers to supervise other people. One staff member said, "Personal care is difficult. If call bells are ringing or people shouting, there is no-one in the lounge, we have no-one to help." Another staff member said, "We have to shower people in the afternoon, we don't do baths. There are set days, we just go through the list. No, we don't have time to chat, that would be nice."
● Oral care was poor. Staff said they did not always have time. Some people had dry, stiff toothbrushes and the person who had slept in the lounge did not have their dentures in. When asked why, they said, "I don't know."
● Staff said breakfast often, 'blended into coffee time at 11am" and "We often finish personal care at 12pm".
● Lack of staffing and the right equipment meant care and support was not always done in a timely way. For example, staff said there was only one moving and handling stand aid upstairs, although the provider said there were two, which meant staff could only support one out of the five people who required this equipment at a time, which slowed them down.
● The housekeeping team told us they often had to help out with care or getting people cups of tea as there were no staff around to assist. Comments included, "We came on shift at 07.30 and [person's name] was very distressed calling out so we got them a cup of tea" and "We helped [person's name] sit on a towel as they were soiled."

Due to lack of sufficient staffing levels, people's needs were not met and people were placed at risk of harm. This is a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff had been recruited safely with appropriate checks completed before staff started working. For example, references had been obtained and checks with the Disclosure and Barring Service (DBS) undertaken to ensure staff were suitable to work with vulnerable people living at the home

Using medicines safely
● People's medicines were administered safely in the way prescribed for them. However, we found areas for improvement for some aspects of the way medicines were managed.
● Improvements were needed to the way 'when required' medicines were managed. Some protocols were in place to guide staff on when it would be appropriate to give a dose of these medicines, but these had not been updated and were not in place for all 'when required' medicines. The time of administration, reason and outcome when these medicines were given was not always recorded in a consistent way.
● Improvements were needed to the way creams and external preparations were recorded. At the time of the inspection two different systems were being used, and this made it difficult to assess whether these preparations were always recorded and applied appropriately.
● We found two liquid preparations in use where the date of opening had not been recorded, where there was a limited expiry period once in use. We were told these were usually replaced each ordering cycle, but it appeared from the volumes in the bottles that this had not happened on this occasion. We were told these would be removed and replaced straight away.
● People's medicines were administered in a safe way. Records showed that people received their medicines as prescribed for them.
● People were supported to administer their own medicines if they wished to, and we saw that suitable checks were made. We saw that risk assessments were completed to make sure this was done safely.
● There were suitable arrangements for the storage of medicines, including those needing extra security.

There were arrangements in place for ordering, and disposal of medicines and suitable records were kept.
● Staff received training in safe medicines management and their competency was checked to make sure they understood the training and gave medicines safely.
● Medicines audits had been completed. The most recent audits showed the areas for improvements we found during our inspection had already been identified, and some suitable actions had been suggested. The provider discussed with us their plans to make the necessary improvements. Medicines incidents or errors were reported and investigated, and measures put in place to reduce the risk of a recurrence.

Preventing and controlling infection
● We saw that housekeeping records showed a large amount of additional deep cleaning was being undertaken by the housekeeping team. They told us this was due to repeated faecal and urinary incontinence on carpets, corridors, chairs and in a bin where people had not been supported to access the toilet. In one room this had happened seven times in September 2021. There were also numerous incidences of the need to clean vomit from carpets and a bed.
● Records showed there had not always been a commercial carpet cleaner available despite the housekeeping team informing the provider this was needed. Therefore, cleaning had had to be done by hand in August 2021. The housekeeping team had done a very good job of keeping the home clean as much as possible despite the additional work, meaning there was no obvious odour throughout the home, only close up to the offending areas.
● We looked at the recurrent soiled areas and found these carpets and chairs to be extremely odorous and asked the provider to replace them as soon as possible, which they agreed to do. Brief environmental room audits had been completed but had not identified these issues. The provider agreed to put these in place immediately.
● Staff had completed online infection control training. However, competencies were not monitored to ensure staff understood their training. We heard from staff that there had been two incidences where staff had not disposed of or handled soiled continence aids correctly.

The environment and furniture were not always clean and hygienic and there was a high level of incontinence which was not managed well. This is a breach of regulation 15 (Premises and equipment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We looked at how the service was managing COVID-19 and found that this was being done well with processes and procedures in place to minimise the spread of infection. Staff consistently wore masks and washed their hands, for example.
● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was meeting shielding and social distancing rules.
● We were assured that the provider was admitting people safely to the service.
● We were assured that the provider was using PPE effectively and safely.
● We were assured that the provider was accessing testing for people using the service and staff.
● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
● We were assured that the provider's infection prevention and control policy was up to date.
● We were assured the provider was facilitating visits for people living in the home in accordance with the current guidance.

Inadequate

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

This is the first inspection for this newly registered service. This key question has been rated Inadequate. This meant there were widespread and significant shortfalls in people's care, support and outcomes.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law; Supporting people to live healthier lives, access healthcare services and support

- Care plans were detailed and generally up to date other than very recent changes. However, it was very difficult to find any health issues, concerns or outcomes, as staff had to read through all the daily notes. Staff said no-one monitored the daily notes and they just wrote what actions they had done. Often daily record entries were timed relating to the time of entry not the action done. For example, breakfast and morning personal care was recorded in the evening.
- More health information was noted in the communication book including doctor's rounds. Staff were unable to find this information unless they read through the communication book. The care plan and computer system did not have the level of detail required for those rounds or show how issues had been addressed. One health professional record said that a person's wound had been dressed but staff could not tell us what wound this referred to. They said the community nurses had left them a dry dressing to use, but there was no record of what wounds the person had currently.
- Another person had a repeated infected groin which required topical cream. Staff were unable to tell us or show us records of how the person's skin was, whether there was progress or deterioration or whether the specialist cream was being used regularly.
- Staff could not show us if there were any health professional referrals in relation to managing a person's behaviours which had resulted in staff being assaulted multiple times. However, the provider told us a referral had been made in August 2021 resulting in a behavioural assessment but there were no actions recorded on the care plan or behavioural charts corresponding with the incidents noted in the daily records.
- On admission there were good assessments completed. However, the information from these was not used in practice. For example, how people liked to be supported and what their preferences where or what social and leisure activities they enjoyed.

Although most health issues appeared to be identified and appropriate referrals to health professionals were made, records did not show clear follow up to ensure people's health needs were met and being effective. This is a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Although the care records did not always enable staff to access clear follow up for health issues, we saw that weekly virtual ward rounds had been carried out with appropriate referrals. For example, to request antibiotics, refer to the community nurses and review medication.

Staff support: induction, training, skills and experience

● Induction was a tick box form and was not followed up by competency assessment. This meant we were not assured learning from induction was embedded into everyday practice to keep people safe and well. A comment on the staff survey in April 2021 stated, 'Induction could be more in depth and preferably by senior staff or management.' Staff confirmed inductions were not always done by senior staff with appropriate experience.
● Staff had all completed online training in mandatory topics such as fire safety, first aid, infection control and food hygiene. However, there was no training relating to care or person-centred care despite this being raised as an issue in staff meetings. The care we saw was task orientated and rushed, with all staff saying there was a routine to follow. One staff member said, "We have tried to change the culture but there are strong personalities in the staff team who don't understand." They said this had been raised with the provider.
● The provider said the service generally specialised in dementia care. There was no evidence of dementia care training or what dementia care occurred in practice.
● The training matrix indicated that six staff were 'for the Care Certificate'. This is a qualification for staff who are new to care work. However, this had not happened.
● Staff had received online training in moving and handling. There had not been any face to face training booked, although this was now available following the COVID-19 pandemic. The lack of practical training placed people at risk. A senior staff member said they had not heard of any face to face training and we did not see any evidence of any being booked.
● Staff were not always using wheelchair footplates as these had to be removed when using the lift and were then not always replaced. This concern had been discussed at a staff meeting three months earlier.
● The use of a low sofa in the lounge had been discussed in the communication book. When people were sat there, staff could not then use the hoist as it did not fit under it. This meant that people had had to be manually handled by staff which put them at risk.
● One person's mobility had recently decreased, staff said over the last few days. The person had had to sleep in the lounge as staff said they did not know how to mobilise them as they were unable to use their frame. A staff member said, "He can only go up to bed if he is strong." By the second day of our inspection this person had been referred to the GP and we had to ask for their care plan to be updated to inform staff of how to manage their mobility.
● Two people had urinary catheters which were changed by the community nurses. However, no staff had had training in catheter care or were able to tell us how they cleaned and managed them day to day. One staff member said, "There was a spray but I'm not sure now."
● Staff said they did not think all staff were competent in delivering care. One staff member said, "On the whole there are some good carers. Some need a lot more training, the good ones have left." Relatives said, "They are capable of looking after him a lot more than me…in fact, I would not be able to look after him at all" and "I have been a Carer myself and I can see that they are trying their best given the difficult current situation."

There were not sufficient numbers of suitably qualified, competent and skilled staff to meet peoples' needs. This is a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Ensuring consent to care and treatment in line with law and guidance
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 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 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 MCA.

In care homes, and some hospitals, this is usually through MCA application procedures 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 had the appropriate legal authority and were being met.

● Records showed the service had referred people for an assessment under DoLS as required, and decisions had been made in people's best interests under the MCA framework. However, people were not routinely involved in decisions about their care or consistently able to have choice and control over all aspects of their support.

● People were consistently not given choice or asked for their consent to care throughout the inspection. Tasks were done when staff determined they needed to do them. People were not asked if they wanted to get up. We saw two staff go into one room, put the light on and start getting someone up by removing their duvet, without allowing the person to wake up, asking for their consent or how they were. They said, "We've come to get you up." This person communicated by displaying behaviours which could be challenging for others at times, including physical aggression towards staff.

● There was confusion with staff about which people had mental capacity to make decisions or what their understanding and communication was. One staff member told us there were two people without mental capacity but the provider told us there were eight people living with dementia who had varying levels of understanding.

● Two staff were currently living in a room upstairs at Oak Wood House with no en-suite. They had lived there for four weeks. Staff told us another staff member had lived in another room upstairs for some months. We did not see any records showing if people and relatives had been consulted.

Care was not consistently delivered with peoples consent and in their best interests. This is a breach of regulation 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Adapting service, design, decoration to meet people's needs

● Oak Wood House is a large, older premises that had plenty of space for people. There was a large lounge with a dining and games table at one end with wide reaching country views. However, the layout of the lounge was not homely or conducive to watching the television as the chairs were all spaced around the edge of the large room.

●The dining room was attractive with further views and nicely laid tables where some people enjoyed reading their newspaper. The provider was sourcing another television so people could also watch television in this area, which was also a library.

● There was a stair lift and appropriate hand and grab rails throughout the building. There were areas for safe storage of equipment. Equipment was regularly checked and cleaned. There had been issues with the main lift. However, the provider had obtained quotes and was addressing the issues with the lift as it had broken down recently.

● Some people at the home were living with dementia. There was minimal signage to aid people in orientating themselves, for example to their rooms or communal spaces which could aid independence. There was also no information available for people about the way the service worked, or menus available each day. There were some signage for the toilet and an activity notice board in the reception area.

We recommend that the provider looks at ways to further promote people's independence around the home and in their daily lives.

Supporting people to eat and drink enough to maintain a balanced diet

● People said they were happy with the food and drink. One person told us, "The food is fantastic. There is lots of choice."

● Mealtimes were at a sociable time in pleasant surroundings. People could eat in their rooms, the lounge or dining room. Kitchen staff assisted with delivering meals which freed up care staff.

●The cook knew what people liked and regularly spoke with people about what foods they enjoyed. The cook attended the residents' meetings where menus were discussed. People had asked for Spaghetti Bolognese and fizzy drinks which had been purchased. People had grown parsley and tomatoes in the summer for use in the kitchen. People thanked the cooks for the lovely standard and variety of food on the menu.

● People who were at risk of losing weight had their intake monitored and were weighed regularly. One person was very reluctant to eat, which was a long-standing issue, and had a particular menu. Staff seemed to know some foods they liked but these were not recorded. The cook said she would devise a list and find a way for the person to choose from a shopping list rather than their imagination. The person liked to store food for later which staff were removing after an hour. The provider said they would consider a fridge in the room so the person could 'graze'.

● Staff told us how they gave people snacks if they asked. One person often wanted something to eat in the night and staff had sandwiches and other items to offer them.

Staff working with other agencies to provide consistent, effective, timely care

● Records showed staff had worked with a range of community professionals to maintain and promote people's health. A weekly virtual ward round was held with health professionals, where people's health needs were discussed.

Inadequate

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

This is the first inspection for this newly registered service. This key question has been rated Inadequate. This meant people were not treated with compassion and there were breaches of dignity; staff caring attitudes had significant shortfalls.

Ensuring people are well treated and supported; respecting equality and diversity.

- The interactions with people and staff were kind and caring when they happened. People commented, "The staff are extremely good, very, very nice," and, "I can't fault the staff, they're so lovely. The cook made me special porridge when I wasn't feeling well." However, the lack of sufficient staffing levels did not enable staff to spend meaningful time with people other than during tasks. Personal care was rushed and delivered as part of a set routine. One staff member said, "Staff are kind, but they have no time."
- Care records contained very little information about people's preferences or how they liked to be supported, especially in relation to getting up and going to bed and how they liked their personal care delivered.
- Night staff told us they had to get people up so the day staff had less of a workload. Staff were not able to tell us when people's preferred time of rising or going to bed was. A record called 'bedtime and rising plan' showed the actual time that people were supported to rise and go to bed. Some people had very early rising times. On our arrival at 6am, two people were up and dressed in the lounge and another person joined them at 6.30am. They then all slept unattended until nearly 8am. One person, who was woken at 6am, told us they preferred to wake up at 8 or 9am.
- One person had had to sleep in the lounge due to staff not knowing how to mobilise them when they could not use their frame. When we arrived, the person said they were cold. They had no pillows and one thin blanket. The communication book also had more than one reminder for staff to remember to keep people warm in the lounge.
- Because the two night staff were busy with one person, the rest of the premises was unattended. As we quietly toured the premises, we heard two people shouting out in their rooms. One person was on a commode with no call bell, another person was lying on their back in bed clearly anxious, calling out. People were either unable to reach their call bells, especially those in the lounge, or clearly needed support and were not receiving a timely response that supported their wellbeing.

Peoples' needs were not being met in a person-centred way. This is a breach of regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Respecting and promoting people's privacy, dignity and independence

- Because staff were unable to effectively manage continence there were a high number of incontinence incidents, often on the floor and furniture. Staff said people were often in soiled continence aids by the time they were able to support people to the toilet. This did not promote peoples' independence or dignity.
- When we arrived at 6am all the overhead communal lights were on throughout the home. There was no

sense that it was early morning and that people may be asleep. A fire door guard was beeping loudly. One person was in their room with the overhead light on in a chair, they had covered their head with a duvet. We asked if they would like the bedside light on and they said yes. Corridors were bright with people's doors open.

● Staff told us they supported people to wash whilst sitting on the commode or toilet. This practice did not promote people's dignity.

People were not treated with dignity and respect. This is a breach of regulation 10 (Dignity and respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to express their views and be involved in making decisions about their care

● Monthly residents' meetings had been held where people expressed their views about aspects of their care, including activities and menus. A 'You said', 'We did', format was used to inform them about what had happened to their suggestions. For example, people had asked for a weekly quiz, gardening, a home cat and a daily newspaper. The outcome was, "There is now a weekly quiz, as soon as the weather is better we will start a gardening club, we can't get a paper delivered but will pick one up when we can and the home cat is being considered." One person said the garden bushes needed trimming to see the view and this was done. People commented, "All the staff are wonderful", and another person said, "They aren't bad." Relatives said, "They treat everyone with respect and you can see they care, but then again, I can't say what happens when I am not there, all seems to be OK" and "The staff are amazing, they care for my father very well and I am grateful for that.

I know they care for him as much as I do, I don't know what I would do without their help!"

Inadequate

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

This is the first inspection for this newly registered service. This key question has been rated Inadequate. This meant services were not planned or delivered in ways that met people's needs.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

- People did not receive personalised care at Oak Wood House. Support was delivered in a routine and transactional way. This was observed by us throughout the inspection, noted in staff meeting minutes and discussed by the Dementia Matters Home Action Team (HAT), launched by the administration assistant in September 2021. The administration assistant said this group had been set up by them when they and the previous manager had identified that care was not person centred. The administration assistant was not trained in care but had wanted to promote better care and culture at the home.
- Staff said they had to follow the routine of the home to get the work done. Staff were allocated to support people by the level of support they needed. This included night staff getting people who were 'doubles' (people who needed two staff to safely assist them) up and in the lounge for the day staff.
- Care plans did not inform staff about how people liked to spend their day or have their support delivered.
- Staff knew what people's likes and dislikes were on admission but did not ask people their preferences on a daily basis. A staff meeting in May 2021 stated, "whilst the breakfast list was useful it could lead to residents being given the same food day after day, it is vital they are given plenty of choice." This showed a lack of choice had been noted previously but not followed up on.
- On the first day of the inspection, one person with mental capacity to make decisions asked us for a cup of tea in his bedroom. We were told by a staff member that he routinely had coffee and came down to the lounge. We had to ask several times for him to get a cup of tea in his room.
- There were no records of when people liked to get up or go to bed. A staff meeting in May 2021 emphasised, "There is no set bedtime or getting up time." This had not been put into practice. Night staff told us they had been told by the acting manager to get one person up before the day shift at 7.30am. who required two care workers and a hoist to mobilise. On the first day of our inspection, the person was up and dressed at 6am in the lounge with all the overhead lights on. They were asleep until 8am. This person lived with dementia and had non-verbal communication. This indicated they were in fact got up before they had had enough sleep.
- Records showed some people were, 'found asleep in the lounge at 11pm', while other people went to bed at 6pm.
- Daily records mostly described task-based information and did not include what people's moods were like or what they had been doing that day. This had been raised in a staff meeting in May 2021, "the details are important so we can see the person behind the data." This was not happening despite some people living with dementia, bereavement, depression and anxiety, which was not commented on or monitored.

Meeting people's communication needs

Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to

follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

● There were no records showing how people living with dementia communicated to inform staff. One person, up from 5.30am, had non-verbal communication but there was no communication sheet. The provider said there had been one in the past and they would ensure one was available. The activity co-ordinator said they had never seen one but had learnt what the person wanted.

Peoples' needs were not being met in a person-centred way. This is a breach of regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

● There was an activity co-ordinator five days a week 10am-4pm. They did a good job in providing activities for people during these times. However, there was no way of auditing their records to ensure individuals were receiving regular engagement that was effective or able to pursue their particular interests.

● Some people chose to stay in their rooms. One person on the first day of the inspection lay on their bed all day with little engagement other than lunch.

● Care workers told us they had no involvement with providing activities, although they were supposed to over the weekend, due to having no time they did not provide any activities. Engagement between people and staff, although by caring staff, was only during tasks.

● There were some one to one sessions, with people in their rooms at times, but mainly, quizzes, nail pampering, armchair keep fit, armchair hoopla, games and skittles. There had also been a minibus to take people to Exmouth which people had enjoyed. Plans for winter events included, a band, Halloween party and fireworks. One relative said, "I am happy with the way they responded to the pandemic… (staff) soldiered on and kept the business going and looking after them."

We recommend that activities and engagement for people are audited to ensure each individual has their social and leisure needs met.

Improving care quality in response to complaints or concerns

● When we asked to see the complaints records the provider said there weren't any complaints.

● There were no formal complaints recorded from people who lived at the home. People did not have any information about the home and how to complain in their rooms or records showing this had been discussed. There was a copy of the complaints procedure displayed in the hallway and the provider said all relatives had a copy of the service user guide.

● There were no records of individual discussions with people about their experience of living at Oak Wood House other than those that attended the residents' meeting.

End of life care and support

● There were no people receiving end of life care and support at the time of the inspection. Care plans contained information about people's preferences for end of life care. However, should a person require end of life support and more one to one care, there would not be enough staff to meet that need.

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.

This is the first inspection for this newly registered service. This key question has been rated 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

- There was no provider oversight to ensure people's needs were met safely. Although there had been regular audits completed such as medicines, falls and environmental, they had not identified the issues we found and were not effective.
- The findings of the audits had not been analysed effectively to improve care delivery. For example, the April 2021 falls audit showed three people had fallen in the early hours or at night. However, the analysis concluded, 'no significance or shortage noted' and no changes had been made to night staffing levels. Four of the five falls in April 2021 had been noted as being in the lounge at different times. The audit form stated, "A staff member is allocated to the lounge and staff are reminded to be vigilant." This had not been happening.
- Issues raised in staff meetings had not been put into practice. At the staff meeting in July 2021 staff had been advised, "The best source of information was the resident notes, and this is ideally the place to record all resident information." However, we found information continued to be documented in different places, with no evidence this had been followed up. For example, one person's three falls had been noted twice in the communication book with a plea for bed rails for this person to stop them falling out of bed. This was three days before our inspection and no action had been taken. We asked for this to be addressed immediately.
- It had been noted in July 2021 that residents were not involved in their care plans. This had not yet been actioned although talked about in a residents meeting.
- The housekeeping records showed where they had had to do unscheduled deep cleaning due to incontinence incidents it had taken a lot of time, meaning the daily cleaning tasks had not all been completed. The acting manager had been informed but no questions had been asked about the volume of unscheduled cleaning relating to poor continence management or additional housekeeping hours explored.

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

- The previous manager had identified that the care at Oak Wood House was not person centred. The senior staff meeting in August 2021 stated, "There is no need to hurry through the day. Getting up and going to bed is entirely at residents' choice." However, there had been no change to the task routine and culture of hurrying every task. Staff said they had repeatedly told the manager there were not enough staff, but the minutes stated, "There are plenty of staff to work steadily throughout the day." There was no dependency

tool used to help determine staffing levels required related to peoples' needs.
● The administration assistant, not a more senior person with appropriate training, had attempted to change the culture by setting up a Dementia Matters Home Action Team (HAT). There had been two meetings, with the most recent in August 2021. This had identified one of the main barriers to providing meaningful, emotional person care was, "a culture of routine and transactional care where we must get X & Y done by a certain time of day." This was a step towards getting away from rigid routines. However, the administration assistant said they had not been able to achieve this so far. In addition, the membership of the HAT had been compromised due to staff sickness and staff leaving.

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 acknowledged they had, "Taken their eye off the ball", and assumed that audits were being effective. They also found it difficult to respond to our concerns or give reassurance to us as they were unable to find information about issues raised through the records.
● Staff felt they had not been listened to when they had raised concerns, especially around staffing levels. During our inspection the provider was receptive to our findings and immediately began to address the issues. For example, a third staff member was added to the night shift. The provider also agreed to change the carpets and furniture we identified as being soiled and put paper records in place to monitor topical creams, continence management and re-positioning. This went some way to mitigating the risks we identified.
● A new manager from the provider's sister home was due to start at the service the following Monday and would begin with devising a dependency tool to analyse staffing levels in relation to people's level of need.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● People and staff had been asked for their views in satisfaction surveys. However, there was no evidence to show comments had been addressed. For example, some people had commented, "more personal shopping", "to go shopping out in the community" and "personal shopping, able to access the shops to get general necessities." The provider said there was an in-house shopping trolley and that some people did access the local shop. The activity co-ordinator said there was no-one to listen to their ideas for future activities, but they continued to do what they could. The provider said they had responded to requests to purchase activity items such as board games and enabling visiting musicians at times. Relatives told us, "I can't say I have seen the manager but if I need something I can always speak to the office" and of the previous manager, "Yes, I know the manager is very good, I don't know the owners, I have never seen them."

Continuous learning and improving care
● Staff meeting minutes, residents' surveys and the communication book showed that issues were raised but then not actioned in practice. There was no learning from these comments or discussions to ensure people's needs were met. The minutes of residents' meetings showed some people had been consulted in some areas.
● There was an acting manager since the registered manager left the service on 21 September 2021. Staff were unable to tell us how they kept up to date or were involved in the wider health community such as the local provider engagement group.

Working in partnership with others
● Although it was difficult to follow up and monitor health issues and outcomes for people, we saw that some health issues were identified and timely health professional referrals made. For example, there was a weekly virtual 'ward 'round' and regular contact with the GP. There were also referrals to the learning

disability team, occupational therapist and community nurses in relation to moving and handling and wound dressings. However, if a health professional required information of progress relating to a health issue it would be difficult to collate the information from various records and would rely on staff knowing what the situation was at the time.

There was a lack of provider and manager oversight to ensure that peoples' needs were met in practice. Audits and meetings showed some issues such as lack of staff and person-centred care had been discussed but no action had been taken to ensure this was addressed. This is a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 15 HSCA RA Regulations 2014 Premises and equipment The environment and furniture was not always clean and hygienic and there was a high level of incontinence which was not managed well.