Oak House (Exeter) Ltd

Oak Wood House

Inspection report

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Ratings

Overall rating for this service	Inspected but not rated

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

Summary of findings

Overall summary

About the service: Oak Wood House is a residential care home providing personal care for up to 18 people aged 65 and over. The service was registered in December 2018. At the time of inspection four people were living at the home and a fifth person was staying for respite care on the first day of the inspection.

People's experience of using this service:
Following a serious incident where a person had died following a fall, the registered manager had undertaken a detailed review of safety features in the home and put in place additional measures to ensure people were kept safe.
However, the quality assurance systems were not robust as they had not identified issues we found during the inspection.

Although risk assessments to support each person had been carried out when they first came to live at Oak Wood House, records did not fully reflect how staff should support the person. Records of what care had been provided by staff also did not reflect all aspects of the care described in people's care plans.

People received their medicines from staff who were trained and competent. However, some aspects of medicine administration did not ensure people received the right medicines. This was because the medicine administration records systems did not ensure that people were clearly identified. Improvements were made to the medicine administration records during the inspection. Medicines were stored safely.

The registered manager was experienced and understood their role. They were working cooperatively with external agencies including the local authority safeguarding team and quality assurance improvement team.

People said they were happy and felt safe living at Oak Wood House Throughout the inspection, staff showed people respect and were very caring and mindful of people's privacy and dignity.

The home was clean and well maintained, with no malodours. People were cared for by staff who followed good infection control procedures.

People were cared for by staff who had been recruited safely. The registered manager ensured that there were sufficient staff with the right knowledge, skills and experience to support people safely. However, the registered manager had not fully identified what staffing was needed at times when staff were supporting people to get up in the morning. By the second day of inspection, action had been taken to address this.

Rating at last inspection: The service had been registered with the CQC in December 2018. Newly registered services are usually inspected within 12 months of the registration date. Therefore, this service had not been inspected following its registration, so the service had yet to be rated in all key areas. Given at this inspection, we only undertook a focussed inspection in two domains, we have not rated the service overall.

Why we inspected: This was a focussed inspection which checked to see whether people were safe and the service was well-led following a serious incident which had occurred in March 2019. During this focussed responsive inspection, we did not inspect the key questions which consider whether the service was effective, caring or responsive as ongoing monitoring did not raise any information about risks or concerns in these areas.

Enforcement Please see the 'action we have told the provider to take' section towards the end of the report.

Follow up: We have asked the provider to send us an action plan telling us what steps they are to take to make the improvements needed. We will continue to monitor information and intelligence we receive about the service to ensure good quality is provided to people. We will return to re-inspect in line with CQC's inspection timescales.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

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.

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

This focussed inspection was prompted in part by notification of an incident following which a person using the service sustained a serious injury and subsequently died. This incident is subject to a police investigation and 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 environmental risks and concerns about safeguarding people from the risks of falls and absconsion. This inspection examined those risks by looking at whether the service was safe and whether it was well led.

As the service was registered on 29 December 2018, it has not been possible to provide an overall rating for the service under the Care Act 2014. A comprehensive inspection will take place within the timescales defined by CQC for new services later in 2019.

Inspection team:
The inspection was carried out by an Adult Social Care inspector

Service and service type: Oak Wood House is a residential care home that was providing personal care for up to 18 people aged 65 and over. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. At the time of inspection five people were living at the home.

The service had a manager registered with the Care Quality Commission. This means that 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:

The inspection was carried out on the 18 and 26 April 2019.

The inspection was unannounced on the first day. We arranged with the provider a date to return for a second day of inspection.

What we did:
Before the inspection, we reviewed information we held on our systems about the service. This included reviewing notifications we had received from the service. A notification is information about significant events which the provider is required to send us by law.

Prior to the inspection we attended a safeguarding meeting called by the local authority's safeguarding service. At this meeting, information about a visit which had been undertaken by a specialist nurse was discussed.

During the inspection we met five people using the service and spoke with two of them to gather their views about the care they received. We also met and spoke with the provider who had registered with the CQC as the manager, their deputy, three care staff and the chef. We reviewed information and records. This included three care records, three medicine administration records, three staff records, audits of the service and other records relating to the running of the service.

Requires Improvement

Is the service safe?

Our findings

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

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. Regulations may or may not have been met.

Assessing risk, safety monitoring and management

● Risk assessments had been undertaken when each person started living at Oak Wood House. Risk assessments included those relating to the person's physical, mental and social risks and needs as well as considering their preferences. However, where a risk had been identified, the care plan developed to support the management of that risk and the daily recordings did not always show how these related to each other. For example, one person was identified as at risk of developing pressure areas due to their immobility. Records of how and when this person was supported to prevent such damage were not accurate or up to date.

● A recording sheet was not individualised as all the people currently living at Oak Wood House were shown on the same sheet and used the same timings. Therefore, people who were currently mobile and less at risk of skin damage were also being recorded as to how frequently they went to the toilet on a fixed time grid. Following feedback, the registered manager agreed to amend this system to evidence personalised support. After the inspection, the registered manager confirmed that systems had been implemented to ensure recording sheets were personalised.

● One person's care record did not include any details about their eyesight being affected by cataracts. This meant staff might not be aware of the person's sight issues which could impact on how they delivered care and support.

After the inspection, the registered manager confirmed that they had updated care records to accurately reflect current information, including details of pending hospital procedures.

● One person was at risk due to their weight. There was no evidence in the care records about what a healthy weight for the person would be. There was no evidence that action had been taken to involve the person, their family the person's GP or a specialist, such as a dietician, in discussions about their weight. The person's capacity to make a decision about what they should eat and drink to manage their weight had not been assessed. The registered manager agreed to consider ways in which the person could be supported to manage their weight.

After the inspection, the registered manager confirmed they had developed an action plan to reflect the risks about the person's weight.

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

● There were environmental risk assessments in place which checked whether Oak Wood House was safe. These included checks on fire safety equipment, window restrictors, refrigerator temperatures as well as the cleanliness of the home.

Staffing and recruitment

• There were usually sufficient staff to support people. However, on arrival on the first day of inspection,

there were only two care staff on duty. Both staff were supporting a person to get up for the day. Other people living at Oak Wood House had already been helped to get up and have breakfast. These people were all downstairs, three of them in the lounge and a fourth person was walking around. Two people had been assessed as at high risk of falls. We discussed this with staff and asked how they would know if a problem arose for any of the people downstairs while they were upstairs. They agreed that there was an issue as they may not hear if a person fell or needed other help. The registered manager explained that normally a third member of staff would have been present downstairs, but they were on leave. They also said they would ensure that staffing was reviewed to ensure this situation would not occur again.
By the second day of inspection, we saw that rotas had been reviewed and that there were sufficient staff on duty to support people safely.
• People were supported by staff who had been recruited safely.
• Pre-employment checks had been carried out before new staff were able to work in the service.
Using medicines safely
● On the first day of inspection the recording of medicine administration did not follow best practice. For example, medicine administration records (MARs) were not filed with dividers in between each person's set of MAR pages; summary information including a photo of the person and significant information about issues such as allergies were not included in the MAR folder. This meant people were at risk of not receiving the right medicines at the right time. By the second day of inspection, the registered manager had taken steps to address the shortcomings of the MARs folder. This included having dividers between each person's MARs with a photo of the person and a list of their allergies and other relevant information displayed.
● Medicines were administered safely by staff who had been trained and had their competency checked.
● Medicines were stored safely in a locked cabinet which was stored in the main office. The trolley was chained to a wall. This ensured only people qualified to administer the drugs had access to them. The trolley was clean and tidy and not overstocked.
● Medicines such as topical creams were labelled with when they were first opened and an expiry date of when they should no longer be used.

We recommend the provider considers best practice medicines administration guidance.

Systems and processes to safeguard people from the risk of abuse
● One person said they felt "very safe" while another commented "I feel very relaxed and happy."
● People were protected from the risks of abuse. There was a safeguarding policy which staff were aware of. Staff were able to describe what they would do if they had a concern about a person being abused. Staff understood how to report concerns and said they would raise issues with the registered manager. They described how they felt confident action would be taken to keep people safe from abuse. They were also able to describe how they would report concerns, if necessary, to the Care Quality Commission and the local safeguarding team.
● People's rights under the Equality Act were protected as staff understood how to protect people from the risks of discrimination.

Preventing and controlling infection
● The service was clean and tidy throughout with no malodours.
Staff had completed training in preventing and controlling infection.
● Staff understood the importance of good infection control processes. For example, staff used personal protective equipment such as disposable aprons and gloves when supporting people with personal care or when undertaking laundry duties.
● There was a cleaning protocol to ensure the kitchen area and equipment was clean and maintaining good hygienic standards.

● There were adequate laundry facilities to deal with dirty and soiled items.
● Staff had completed food preparation and hygiene training to ensure they understood how to prepare, store and serve food safely.

Learning lessons when things go wrong
● The registered manager and staff had investigated a serious incident which had occurred and identified learning which had reduced the risk of a recurrence. This had included improving environmental factors such as window locks and restrictors.
● The registered manager and staff had worked positively with the local authority safeguarding team to address concerns raised following the serious incident.
● The registered provider was also working with the Local Authority's Quality Assurance and Improvement Team (QAIT) to ensure that the systems and processes to keep the service safe were appropriate and adequate.

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

Service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care. Some regulations may or may not have been met.

Planning and promoting person-centred, high-quality care and support with openness; and how the provider understands and acts on their duty of candour responsibility

- Some care planning did not fully ensure that care was delivered in line with the assessments of people's risk and needs.
- The service had understood the importance of being open and honest and acting within their duty of candour responsibilities. For example, where a serious incident had occurred, the registered manager had been in contact with the family to support their understanding of what had happened. Information had also been shared with professionals appropriately.

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

- Quality assurance systems had not identified and addressed some issues found during the inspection. For example, staffing levels and deficits in care records. Although deficits in medicines administration records and processes had been identified and a new process was planned, no action had been taken during the intervening period to ensure medicine administration records followed national guidelines.

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

After the inspection the registered manager confirmed that action had been taken to address the issues.

- There was a registered manager who was also the provider. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The registered manager had experience of running another home.
- The registered manager was clear about their role both as registered manager and as a provider. They explained that they intended to step down from the role as registered manager in the near future and had appointed a person who would take over from them in this role. They explained that they would continue to monitor the governance of the home as well as the safety and quality of the care. They said they believed that by separating the two roles, this would provide stronger governance and management.
- People living at the home knew the registered manager and said they had confidence in her.
- Staff said they felt supported by the registered manager and felt able to discuss issues and concerns with her. They said they were confident that she would take action where necessary.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● The service had only opened in January 2019 and therefore systems to engage with people using the service, the public and staff were still in their infancy. However, the registered manager had a clear understanding of their responsibilities to work within the requirements of the Equality Act 2010, ensuring that people were treated as individuals without fear of prejudice based upon any of the equality characteristics.

Continuous learning and improving care

● There was a culture where continuous learning was undertaken to ensure that risks, issues, concerns and complaints were seen as opportunities to improve care at Oak Wood House.

● Following our inspection, the registered manager provided information relating to learning which had arisen from the inspection.

Working in partnership with others

● The provider and staff had worked in partnership with health and social care professionals. Advice from health professionals such as people's GP had been sought when people became unwell.

● Staff also worked in partnership with families, relatives and friends to support people as they had moved into Oak Wood House.

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 12 HSCA RA Regulations 2014 Safe care and treatment Medicines were not always being managed in line with best practice. Care records did not describe fully people's risks, needs and preferences. Where risks had been identified, the plans and daily notes did not fully describe the care needed or delivered

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The systems for governance were not sufficiently robust to have identified the issues we found on inspection