Mondial Care Ltd

Oakland Nursing Home

Inspection report

Whitepoint Road
West Cliffe
Whitby
North Yorkshire
YO21 3JR

Tel: 01947602400

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Oakland Nursing Home is a nursing home providing personal and nursing care to up to 27 older people. At the time of this inspection, 20 people were using the service.

People's experience of using this service and what we found
Risks in relation to the transmission of infections, the environment and risks specific to people's medical conditions had not always been fully considered or recorded.

Staff had completed medicines training; however, medicine records were not always thoroughly completed. Accidents and incidents had not been fully reviewed to identify any trends.

Systems and processes in place to monitor the quality and safety of the service provided had not always been effective in highlighting shortfalls. Where they had identified issues, timely action had not always been taken to respond. The registered manager had not always taken action to respond to and address any complaints made within the required timescales.

People told us they felt safe. Staff had received safeguarding training and knew the process to follow if they had any concerns. There was enough staff on duty to ensure people's care and support needs were being met. Staff had been recruited safely and recruitment processes were followed.

The provider and registered manager were responsive to the concerns and shortfalls found at the inspection. The registered manager was new to their role and they were committed to ensuring lessons were learnt when things had gone wrong. They were keen to improve the service.

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

Rating at last inspection
The last rating for this service was good (published 5 February 2019).

Why we inspected
We received concerns in relation to infection control and record keeping. As a result, we undertook a focused inspection to review the key questions of safe and well-led only.

We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.

The overall rating for the service has changed from good to requires improvement. This is based on the findings at this inspection.

We have found evidence that the provider needs to make improvement. 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.

We have identified breaches in relation to assessing the safety of the service and governance processes in place at this inspection.

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

Follow up
We will request an action plan 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.

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.

Oakland Nursing Home

Detailed findings

Background to this inspection

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

Service and service type
Oakland Nursing Home 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 had a manager registered with CQC. 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
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection including recent whistle-blowing and relative concerns. We sought feedback from the local authority and professionals who work with the service. We used all of this information to plan our inspection. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they

plan to make. We took this into account when we inspected the service and made the judgements in this report.

During the inspection
We spoke with the registered manager, clinical lead, three care staff. We conducted a tour of the service to look at infection, prevention and control and Covid-19 management and observed staffs' practice. We also spoke with three people who used the service.

We reviewed a range of records relating to infection, prevention and control and Covid-19 management. We also reviewed four people's care files, staff files relating to recruitment, training and supervision and a variety of records relating to the management of the service.

After the inspection
We continued to seek clarification from the provider to validate evidence found and clarify action taken to address the shortfalls found. We looked quality assurance records, audits and staff correspondence.

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 good. At this inspection this key question has now deteriorated to requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Assessing risk, safety monitoring and management

- Risks to people had been identified. Records did not always provide staff with thorough guidance on how risks should be managed.
- Records in place to monitor known risks were not always updated. For example, where people required a specific amount of fluid each day, this had not been consistently recorded to evidence sufficient fluids had been provided.
- Risk relating to the environment had not always been considered. There was no record of regular checks of areas such as fire prevention, bedrails and window restrictors.

Failure to assess the risks to the health and safety of service users is a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely

- Medicines had not always been stored, administered and recorded appropriately.
- Where people were prescribed 'as and when required' medicines, appropriate protocols to provide staff with guidance as to when to administer were not in place.
- Prescriber instructions had not always been followed where people required a varied dose of medicine.

Failure to safely manage medicines 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

- We were not assured that the provider's infection prevention and control policy was up to date. The policy in place was not specific to the service. Risk assessments had not been completed for service users or staff in relation to the risks posed by Covid-19. The IPC audit completed had not identified the issues we found during the inspection.
- We were somewhat assured that the provider was preventing visitors from catching and spreading infections. Visitors guidance was in place, but this was out of date and did not correspond with the most up to date government guidance. There was a lack of posters and guidance displayed around the service.
- We were somewhat assured that the provider was promoting safety through the layout and hygiene practices of the premises. Records were not kept in relation to the regular cleaning of communal areas and areas that posed an increased risk of transmitting infections, such as door handles.

Failure to assess and manage the risk in relation to the spreading of infections was a breach of regulation 12

(Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● 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 have also signposted the provider to resources to develop their approach.

Learning lessons when things go wrong
● Lessons had not always been learnt when things went wrong.
● Accidents and incidents were recorded but they had not been monitored to identify any trends or action that could be taken to reduce risks further.
● Complaints had not always been appropriately addressed and responded. There was no evidence lessons had been learnt as a result of complaints made.

Failure to assess, monitor and improve the quality and safety of the service provided was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse
● Systems and processes were in place to safeguarding people from abuse.
● Staff had completed safeguarding training. The registered manager and staff team were clear about their roles to report any concerns.

Staffing and recruitment
● People told us staff responded to their needs in a timely manner. Comments included, "There are plenty of staff around."
● Rotas showed there was not always a suitable number of staff on duty. At night there were only two staff to support 20 people, most of whom required two staff to support them with their needs. The registered manager agreed this number needed increasing. They took immediate action to address this.
● Recruitment checks had been completed to ensure suitable staff were employed. Records did not always clearly evidence interviews had taken place.

Requires Improvement

Is the service well-led?

Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

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

- Systems and processes in place had not been operated effectively to ensure compliance with regulations. The registered manager had failed to identify and address poor practice in relation to Covid-19 management and there were shortfalls in some records.
- Governance systems in place used to monitor the quality and safety of the service provided had not considered all areas, specifically in relation to Covid-19 and risk assessing. Where audits had been completed, these failed to identify and address all issues and shortfalls in a timely manner.
- The provider had not visited the service on a regular basis. They were not fully aware of the shortfalls within the service. Weekly reports produced by the registered manager and sent to the provider did not cover all areas of the service.

Failure to establish and operate effective systems to assess, monitor and improve the service provided was a breach of Regulation 17 (Good Governance) of the of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The registered manager were keen to learn and improve. They recognised the shortfalls found and accepted support from the local authority to embed improvements.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

- The registered manager had not always followed their own complaint process when responding to concerns raised.
- People and staff spoke positively of the management team. Staff felt the service had an open and honest culture. One staff member said, "I love working here. [Registered manager] is quite new but they are lovely and really approachable."
- Staff were encouraged to share their views and contribute to changes within the service.
- The registered manager understood the importance of leading by example. They had recently moved their office to a location that was accessible to people and staff in order to promote an open culture.

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

characteristics; Working in partnership with others

● Staff had used technology and regular telephone calls to engage and involve people who used the service with relatives during Covid-19 restrictions. A visiting area had been created and utilised where possible.

● Staff at the service had strong links with other health and social care professionals. Visits from other professionals had continued to take place, in a safe way, during Covid-19 restrictions to ensure people had access to the care and support they needed.

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 The provider failed to assess the risks to the health and safety of service users. The provider failed to manage medicine safely and failed to assess and manage the risk in relation to the spreading of infections. 12(2)(a)(b)(d)(g)(h)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to assess, monitor and improve the quality and safety of the service. They also failed to establish and operate effective systems to assess, monitor and improve the service. 17(1)(2)(a)(b)(c)