Anchor Hanover Group

Oulton Manor

Inspection report

3 Wakefield Road
Oulton
Leeds
West Yorkshire
LS26 8EL

Tel: 01132828222

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Ratings

Overall rating for this service	Requires Improvement
Is the service safe?	**Inadequate**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

About the service
Oulton Manor is a residential care home providing accommodation and personal care for up to 77 older people. At the time of our inspection there were 68 people using the service. Oulton Manor is a purpose built home and accommodates people over three floors. People living on the ground floor require support with residential care needs. The first and second floors support people with more complex needs including people who are living with dementia.

People's experience of using this service and what we found
People were not always safe. They were at risk of harm as the provider had not assessed and mitigated the risks to people. Medicines were not managed safely.

There were not enough staff to keep people safe. We saw staff were generally kind and caring, but they were rushed, and routines were often task orientated. They were not able to respond quickly to people when they needed care, support or comfort. People were not always protected from abuse. Where there were events such as accidents, measures were not put in place to prevent events happening again. Recruitment was managed safely.

Oulton Manor was very well maintained and provided high quality, luxurious and spacious accommodation for people. People were protected from the spread of infection because good systems and processes were in place. Most people and relatives said they felt safe living at the home and spoke positively about the staff who cared for them.

The provider was unable to demonstrate robust governance arrangements. Systems and processes were in place, but they had failed to identify shortfalls and drive improvement. We received mixed feedback from staff and relatives about the management of the home.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

The provider was responsive to our inspection findings and responded during and after the inspection. They shared updates about what action they were taking, including a detailed action plan.

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

Rating at last inspection
The last rating for this service was requires improvement (published 7 April 2020) At our last inspection we recommended that improvements were made to ensure risk assessments were updated appropriately and governance processes were more robust. At this inspection we found the provider had not acted on the

recommendations and we identified ongoing shortfalls in both these areas.

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Why we inspected

We received concerns in relation to the management of medicines and safe staffing levels. As a result, we undertook a focused inspection to review the key questions of safe and well-led only. For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating. The overall rating for the service is requires improvement. This is based on the findings at this inspection. The service has been rated requires improvement for the last two inspections.

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 and well-led sections of this report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Oulton Manor on our website at www.cqc.org.uk.

Enforcement and Recommendations

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 and will take further action if needed.

We have identified breaches in relation to safeguarding, safe care and treatment, medicines management, staffing and good governance.

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

Follow up

We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and the local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not safe.

Details are in our safe findings below.

Inadequate

Is the service well-led?

The service was not always well-led.

Details are in our well-led findings below.

Requires Improvement

Oulton Manor

Detailed findings

Background to this inspection

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

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 first day of the inspection was carried out by three inspectors. The second day of the inspection was an evening visit and was carried out by two inspectors. The third day of the inspection was carried out by three inspectors. An Expert by Experience contacted relatives of people who lived at Oulton Manor on the telephone to discuss their experiences of the care. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
Oulton Manor is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Oulton Manor is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. 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. At the time of our inspection there was a registered manager in post.

Notice of inspection

The inspection was carried out over three dates, including an evening visit. The visits were unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We spoke with four people who used the service and 18 relatives about the experience of the care provided. We looked around the building and observed people being supported in communal areas. We spoke with 15 members of staff including the registered manager, district manager, team leaders and care staff. We spoke with one health care professional. We had a meeting with the registered manager and senior managers after the second day of the inspection to discuss our concerns about staffing levels.

We reviewed a range of records. This included 11 people's care records and multiple medication records. We looked at four staff files in relation to recruitment and a variety of records relating to the management of the service, including audits and polices.

Inadequate

Is the service safe?

Our findings

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

At our last inspection we rated this key question requires improvement. At this inspection the rating has changed to inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong

At our last inspection we recommended the provider reviewed their systems and arrangements to ensure all risk assessments were current and incidents investigated fully to mitigate the future risk to people. At this inspection we found this had not been addressed.

● Risks relating to people's skin integrity, mobility, nutrition and mental health were not always assessed and monitored effectively. We reviewed 11 people's care records and found shortfalls in all. This meant people were exposed to an increased risk of harm.
● Where people experienced distress and anxiety, which posed a risk to other people, the risk was not effectively managed. One person had experienced heightened periods of anxiety. This resulted in their mood and behaviour being unsettled and there were occasions when they hit out at other people living at the home. Risk assessments had not been updated to reflect this. This meant the person was not supported consistently and there was an increased risk of harm to themselves and other people they lived with.
● Records showed us there was a high level of unwitnessed events including falls. For example, one person had five falls within a 9 day period when staff were not present. Their risk assessments had been updated to indicate the risk was high but there had been no changes made to their care plan although other records indicated there had been significant changes in their health.
●The provider had assessed some people required sensors to ensure staff were aware of their movements and could provide timely support. We found the sensors were not used effectively. For example, two staff who were working a night shift were not aware one person had a sensor in place. We checked the person's room and the alarm had not been turned on. We found another person did not have a sensor mat in place by their bed and another person was not positioned on a pressure relieving cushion. This put people at an increased risk of harm.
● Accidents and incidents were recorded and reviewed. The system generated clear information about themes and trends. However, this was not always acted upon and the necessary updates to people's risk assessments after events happened had not always been made. This meant there was an increased risk of a reoccurrence.

We found systems were not robust enough to demonstrate the risks to people's health and safety were effectively managed. This placed people at risk of harm. This was a breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Routine safety and environmental checks were in place. A dedicated maintenance team ensured high standards were maintained. The home was luxurious and spacious. We received very positive feedback

about the home. One relative said, "It is like a five star hotel, spotlessly clean." Another relative said, "The place is beautiful."

Using medicines safely

● The systems in place for giving people their medicines were not always safe.

● Appropriate protocols were not in place to ensure people received their medicines in line with instructions. For example, where people required medicines before or after food, there was no specific procedure in place to ensure this happened. We saw one person being given their medicine after their breakfast, which should have been given before food.

● Some people were prescribed medication which had to be given at specific times in order to be effective, such as for Parkinson's disease and pain relief. Staff were not recording the time they administered medication to people. This meant we were unable to confirm people had received these medicines safely and as prescribed.

● Care plans in relation to medicines were not always comprehensive and up to date. For example, we saw one person who had been refusing their medicines and had some changes to their medicines. However, their medicine care plan had been in place since October 2021 and the monthly care plan reviews had not identified the changes in the person's health and well-being.

● Staff had their competency to administer medicines assessed annually. We found shortfalls in the provider's processes which meant we were not assured staff had the necessary knowledge and skills to administer medicines safely.

We found systems were not robust enough to demonstrate medicines were managed safely. This placed people at risk of harm. This was a further breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

● Safe staffing levels were not always in place and staff were not always effectively deployed. This meant people were at an increased risk of harm or injury.

● Over the course of the three days we observed people did not always receive timely support and communal areas were often left unsupervised. We visited the service one evening and found most people were still up and continued to require high levels of care and support with eating and drinking, personal care and mobilising. However, at 7pm the staffing levels significantly reduced. During the day there were 14 staff to support 67 people over three dedicated units but after 7pm there was only seven staff.

● Staffing levels were calculated using a dependency tool. This was regularly reviewed to inform the staffing levels. However, as a result of our observations we concluded this was not always effective.

● Records showed us there was a high level of agency staff. The provider told us they tried to ensure consistent staff were deployed but rotas showed this was often not the case. Staff also told us they had concerns about staffing levels and the high ratio of agency staff and lack of consistency.

● We received mixed views from people and relatives about staffing levels. Some relatives said they thought staffing levels were appropriate, but others raised concerns. One relative said, "I have never known it to be without enough staff." Two people who lived at the home told us they often had to wait for support. One person said, "Staff are very busy. It's chaotic. There are not enough of them."

Systems were either not in place or robust enough to demonstrate there were enough staff deployed to care for people safely. This placed people at risk of harm. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We met with the provider after the second day of the inspection. The provider assured us they would

increase staffing levels immediately on a night and complete a robust review of their dependency tool to identify the appropriate staffing levels to keep people safe. They also took steps to increase the consistency of temporary staff working at the home.

● Safe recruitment practices were followed. The registered manager explained there was a rolling programme of recruitment and plans were in place to support apprentices to join the team.

Systems and processes to safeguard people from the risk of abuse
● The provider's procedures failed to safeguard people from the risk of abuse. Where safeguarding events had taken place, effective action was not always taken to mitigate the risk of the same thing happening again.
● We received multiple comments from relatives and staff about people's personal items not being appropriately safeguarded by the home. We were told expensive items such as jewellery had gone missing and there was a lack of respect and care for people's clothing. The provider told us they encouraged people not to bring expensive items and where they did inventories were in place. We did not see any evidence of any inventories.

The provider failed to demonstrate people were safeguarded from abuse and neglect. This placed people at risk of harm. This was 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.

● We received mixed feedback from people and relatives. Most people said they felt safe, although some relatives expressed worries about things that had happened at the home.
● Staff had received safeguarding training. They were able to describe different forms of abuse and what action they would take if they witnessed this.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The MCA requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the Mental Capacity Act (MCA). In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS)

● We found the service was working within the principles of the MCA and if needed, appropriate legal authorisations were in place to deprive a person of their liberty. Any conditions related to DoLS authorisations were being met.

Preventing and controlling infection
● We were assured that the provider was preventing visitors from catching and spreading infections.

● We were assured that the provider was supporting people living at the service to minimise the spread of infection.

● We were assured that the provider was admitting people safely to the service.

● We were somewhat assured that the provider was using PPE effectively and safely. We observed examples where staff were not wearing face coverings properly. We discussed this with the registered manager, and we were assured they would address this.

● We were assured that the provider was responding effectively to risks and signs of infection.

● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.

● 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.

The provider was supporting relatives and friends to visit people safely. We saw relatives and friends were welcomed and could spend time with their relative where they preferred. The appropriate safeguards were in place to protect people.

Requires Improvement

Is the service well-led?

Our findings

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

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

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

- At our last inspection we recommended the provider reviewed their governance systems to highlight inconsistencies and recording issues to ensure records were accurate and systems effective. The provider had failed to make the necessary improvements.
- Further significant shortfalls were found at this inspection. We found breaches of regulations relating to medicines, the management of risk, staffing, safeguarding and good governance. Systems were in place, but they had been ineffective in ensuring the provider was compliant with regulations.
- Systems to manage the risks to people's health and safety were not always effective. Records relating to people's care were not always accurate and up to date. This meant people were at a heightened risk of injury and their health and well-being deteriorating.
- The provider had systems in place to assess staffing levels. However, our observations identified concerns about people's safety due to there not being enough staff available.
- Audits were in place and whilst some were effective, they had not highlighted the shortfalls we found with medicines and risk management.

People were placed at the risk of harm through the lack of effective governance systems. This was a breach of regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The registered manager had complied with the requirement to notify CQC of various incidents, so we could monitor events happening in the service.
- The provider responded positively to our feedback during and after the inspection. They confirmed action they had taken to make improvements.

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

- People and their representatives had not always been involved in their care planning.
- We received mixed feedback from relatives about the effectiveness of the registered manager. Some

relatives were positive and said they were approachable and helpful. However, other relatives said they had poor experiences and lacked trust in them responding to concerns and complaints.

● There was a team leader based on each unit. Relatives spoke very positively about the support they offered. One relative said, "The seniors are marvellous and go above and beyond." Relatives also complimented the care staff. One relative said, "All the staff are lovely, friendly and all smiles."

● Most staff said they found the registered manager approachable. However, we received varied views about teamwork at Oulton Manor. Some staff gave us examples of good team working but other staff said they thought morale was low and when concerns were raised, they were not dealt with. They said this impacted on the quality of care people received.

● There was an App in the home's foyer which provided visitors with the option to give on the spot feedback about their experiences of visiting. The results of this were positive and where issues had been raised there was evidence this had been followed up. The registered manager told us they had plans to develop more options for people's relatives to be involved in activities at the home. The provider sent a monthly newsletter to relatives.

● The home had an activity coordinator and there were opportunities for a range of person centred activities during the day.

Working in partnership with others

● Records showed staff engaged with a range of health and social care professionals.

● We spoke with a visiting health care professional and they spoke positively about partnership working. They visited the home regularly and complimented the team leaders. They said, "They are on the ball. I would say they go above and beyond."

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 or manage the risks associated with people's care. Reg 12 (1)(2)(a)(b) Systems were not robust enough to demonstrate the safe and proper use of medicines. Reg 12 (1)(2)(g)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider failed to safeguard people from the risk of abuse and improper treatment. Reg 13 (1) (2)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to operate an effective governance system to ensure compliance with requirements. Reg 17 (1)(2)(a)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider failed to ensure there were sufficient suitably qualified and experienced staff deployed to keep people safe. Reg 18 (1)

(2) (a)