Oakleaf Westmidlands Limited

Oakleaf Nursing Home

Inspection report

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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
Oakleaf Nursing Home is a care home providing personal and nursing care for up to 59 people, aged 65 and over. At the time of our inspection 13 people were using the service.

People's experience of using this service and what we found
We found the home was in need of redecoration and repair to provide people with a homely environment. Furniture that was being used by people was not always clean. Staff were not always following guidelines to prevent the spread of infection.

There were systems to audit and monitor the service in place, but these did not always identify issues such as gaps in the recruitment process. The provider and registered manager had improvement plans in place and had concentrated on establishing a skilled staff team and safe working practices to promote good health for people.

People's care was not always person centred and there was a lack of meaningful activities taking place. Care plans had not been updated during COVID-19 to address the impact it was having on people's social activities. The home could not demonstrate what steps had been taken to combat the risk of social isolation to people.

We found people were protected from potential abuse and avoidable harm by staff that had safeguarding training and knew about the different types of abuse. People's medication was managed safely and people with health risks were regularly monitored.

We found there were sufficient numbers of staff members on duty and people felt safe. Staff spoke positively about working for the provider. They felt supported by management and valued in their role.

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

Rating at last inspection
This service was registered with us on 01/10/2019 and this is the first inspection of this service under the new provider.

Why we inspected
The inspection was prompted in part due to concerns about the history of the service requiring improvement. 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 remained requires improvement.

We have found evidence that the provider needs to make improvements. Please see the safe and well led sections of this full report.

Follow up
We will continue to monitor information we receive about the service until we 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.

Oakleaf 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 the inspection we looked at the infection control and prevention measures in place. This was conducted as part of our Thematic Review of infection prevention in care homes.

Inspection team
The inspection was carried out by two inspectors and a specialist advisor who had a nursing background.

Service and service type
Oakleaf 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 home consists of two floors, with only the ground floor being used at the time of our inspection.

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
We gave the service 24 hours' notice of the inspection. This was because we needed to establish the current status of residents and staff members in relation to COVID-19.

What we did before the inspection
We reviewed the records held on this service. 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.

This is the first inspection of Oakleaf Nursing Home since the service had a change of provider. We reviewed information we had received about the home since this change took place. We sought feedback from the local authority and other professionals who work with the service. We used all of this information to plan our inspection.

During the inspection
We spoke with four people who used the service and telephoned four relatives about their experience of the care provided. We spoke with nine members of staff including the nominated individual, registered manager, finance manager, nurses, senior carers, carers and domestic staff. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

We reviewed a range of records. This included three people's care records and multiple medication records. We looked at two 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 staff rotas and health and safety documents.

Requires Improvement

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 of this existing service under new ownership. This key question has been rated 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.

Preventing and controlling infection

- We observed that some furniture being used by people was soiled. One relative told us they had regularly noticed furniture was dirty. We raised this with the registered manager who said they would address this with domestic staff.
- The home was in need of redecoration and repair. We saw flooring in the communal areas and people's rooms was worn and ceiling tiles that were stained. We found a broken door handle when we entered a bathroom. The registered manager and provider had action plans in place which had identified the need for renovation work.
- Staff were not always following government guidance for preventing the spread of infection. We saw people being supported to eat meals by carers who were not wearing gloves.
- We observed staff wearing masks and aprons for supporting people and there was an adequate stock of these in the home.
- We observed domestic staff cleaning the environment and cleaning schedules were in place. However, the cleaning rota was not effective in identifying the soiled furniture we had noted.

Assessing risk, safety monitoring and management

- Care plans were updated after incidents to reduce the risk to people's health and safety.
- Risks to people's safety were assessed and managed. Care plans and staff handovers were in place. Staff we spoke to were aware of people's needs and knowledgeable about how to keep people safe. We saw one person being supported by staff to safety reposition in their chair.
- People at risk of malnutrition, dehydration and sore skin had regular monitoring which was consistently recorded and reviewed. This meant that people received the right care for their health needs.
- One relative told us that their family member's health had improved significantly since the new provider took over the service.

Staffing and recruitment

- Staff had not always been recruited safely by the new provider. Gaps in one person's employment history were not explored and their references were not dated or validated to ensure they had been checked as accurate. This meant recruitment processes were not always effective in ensuring staff were suitable for the roles prior to employment. The registered manager told us they would look into this.
- There were sufficient numbers of staff to meet people's needs. Staff told us they had time to care for people. One person said, "When I ring the bell they come quickly. They work hard."

Learning lessons when things go wrong

● The registered manager reviewed accidents and incidents monthly but did not have a system in place to identify any themes or trends. The registered manager told us that moving forward they would put this in place.

● The registered manager discussed how lessons had been learnt when things had gone wrong. For example, after a safeguarding matter at the service, changes were made to systems to reduce the risk of it happening to others.

Systems and processes to safeguard people from the risk of abuse

● People were protected from potential abuse and avoidable harm by staff that had up to date safeguarding training. Staff were able to tell us the signs of potential abuse and what they would do to raise concerns.

● People and staff told us they thought people were safe. Most relatives said they thought people were kept safe at the home.

● One concern was raised by a relative about the safety of their loved one prior to our inspection. This is being investigated by the local authority safeguarding team.

Using medicines safely

● Medicines were managed to ensure people received them safely and in accordance with their health needs.

● There were protocols in place for PRN medicines [as and when required]. Staff were knowledgeable about how and when to give these medicines.

● Where people required medications covertly, appropriate documentation was in place to ensure it was given in people's best interests. Covert medication is the administration of any medical treatment without the person knowing.

● Controlled drugs were stored correctly and staff kept accurate records. Controlled drugs are treatments which have specific rules for administration and storage.

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.

This is the first inspection of this existing service under the new provider. This key question has been rated requires improvement.

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

- The registered manager did not regularly gather feedback from people and relatives but planned to do so annually. This meant there was no system in place to evaluate how happy people were with the service and to drive improvements.
- The registered manager told us, and records confirmed, audits had taken place and action plans had been created that identified areas of improvement. Much of the improvement plan for the home environment had been put on hold due to COVID-19. However, there were some areas that the registered manager had not identified as part of their audit process.
- People's support plans had not been updated to consider the impact of social isolation caused by COVID-19 restricting visitors and activities. This had not been identified by the provider's systems.
- Audit systems and processes had not identified the shortfalls we found in one recruitment record we reviewed.
- Systems in place to monitor staff practice did not identify staff were not complying fully with all aspects of government guidance in relation to wearing protective equipment.
- Systems in place to monitor the quality of care and facilities was not robust. The registered manager had a daily 'walk about' to spot check staff practice, equipment and the environment. However, we found that this did not highlight the maintenance and hygiene issues we had noted.
- The registered manager dealt with accidents and incidents on a case by case basis. This meant there was not a formal system for highlighting themes and trends amongst incidents at the home.
- We raised the above concerns with the registered manager and provider who said they would address these as part of their service action plan.
- The registered manager told us they regularly checked with staff about their knowledge of safeguarding and opened conversations.
- Staff said they felt able to talk to management about any concerns they had.
- The registered manager had notified The Care Quality Commission (CQC) of events which had occurred in line with their legal responsibilities.

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

- People's care was not always person centred. The activity board in the home was not updated and we observed a lack of meaningful activities taking place for people. One person told us there was 'not a lot' to do. Another relative said, "The atmosphere was very quiet; not many people about. It was a bit like a

hospital."
● Care plans for people's social and emotion needs were not person centred and didn't identify people's individual wishes and preferences.
● The registered manager acknowledged that improvements were needed to promote a person-centred approach, however their focus had been on improving safety in the home. The registered manager told us activities had been impacted by COVID-19. However we raised internal activities had not been considered for people.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● The registered manager and provider had set up a system of garden visits so that people could see friends and relatives through the windows. This meant that people could keep in touch with loved ones whilst minimising the risk of infection.
● Relatives told us there was a lack of communication since the pandemic began and the home closed to internal visitors. One relative told us they had waited six weeks for the home to contact them after lockdown began. The registered manager informed us there had been regular calls taking place.
● Staff felt their work was valued and they were able to approach the management team as needed. One staff member said, "If I had a problem I would go to them, a nurse, the manager or director. [The registered manager] is good. [The registered manager] has time for us."

Working in partnership with others; Continuous learning and improving care
● The provider had been working with the Clinical Commissioning Group towards an improvement action plan at the home. This meant that they were working towards improvements in the service. Documents show that some objectives require further action from the home.
● The provider put an improvement plan in place when the service was taken over. The progress of renovation works had been impacted by COVID-19. We raised that the external area could be addressed to provide people with a pleasant area to enjoy. For example, a damaged smoking shelter meant that people were exposed to the elements.
● The registered manager and provider acknowledged that continuous learning and improvement was required. One staff member told us, "There has been a big improvement [since the new provider]. There are less residents now, but the change has been amazing."

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 understood their responsibility in relation to duty of candour.