Unity Homes Limited

Oakbank Care Home

Inspection report

Oakbank
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Manchester
Greater Manchester
M9 5YA

Tel: 01612058848

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08 July 2020
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10 July 2020
13 July 2020

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Oakbank Care Home is a care home providing personal and nursing care to 39 people aged 65 and over at the time of the inspection. The home can support up to 55 people across two floors. The ground floor supports people with nursing care needs and the first floor supports people with residential care needs.

People's experience of using this service and what we found
Risks to people were not robustly assessed, mitigated and reviewed. Staff did not have clear direction of how to manage the risks people presented, which put people at risk of harm or injury. People were using equipment without being safely assessed to do so. Risk assessments did not accurately capture people's needs and were not always incorporated into care plans. Some care plans were not descriptive of people's current needs and did not give the guidance to support people effectively.

Staff could not always describe how to support people safely. Agency workers were used across the home, but they did not always receive a robust induction or the opportunities to learn about people's care and support needs. Personal Emergency Evacuation Plans (PEEPs) needed further work to be reflective of people's moving and handling needs.

There had been no learning from previous falls in the home that had led to injury. Audits to monitor care plans and risk assessments did not identify the concerns we found where the assessments lacked person-centred detail or areas for improvement.

There was a lack of clinical oversight at the home and there had been no deputy manager in post for over a year. The registered manager told us it was sometimes difficult to keep on top of things and additional support had been sourced from a compliance manager prior to the inspection.

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 6 July 2019).

Why we inspected
The inspection was prompted in part by notifications of death and specific incident. Following which people using the service died or sustained a serious injury.
These incidents are subject to investigation. As a result, this inspection did not examine the circumstances of those incidents.

The information CQC received about the incidents indicated concerns about the management of falls. This inspection examined those risks and a focused inspection was undertaken 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 safe and well-led sections of the report.

You can see what action we have asked the provider to take at the end of this full report.

Following the inspection, we sent a Letter of Intent to the provider to seek assurances on the concerns we raised. The provider provided a response which assured us of the actions in place to improve the management of risks to people.

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

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 found breaches in Regulation 9 (Person-centred care), Regulation 12 (Safe care and treatment) and Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 from the provider detailing 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?

Inadequate

The service was not well-led.

Details are in our well-Led findings below.

Oakbank Care 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.

Inspection team
The inspection team consisted of two inspectors. Three inspectors made phone calls to staff members and the families of people living in the home. We inspected the home on the first date of inspection and followed up information by email and telephone calls on the second, third and fourth days of the inspection.

Service and service type
Oakbank Care 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 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 48 hours' notice of the inspection. This was because we needed to discuss the safety of people, staff and inspectors with reference to COVID-19.

What we did before the inspection
Prior to the inspection, we reviewed information we held about the service since the last 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
During the inspection, we spoke with the registered manager, the compliance manager and the director of the home. We also spoke with five people living at the home.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We spoke to 12 staff members and four family members by telephone.

We reviewed seven care plans and risk assessments, information relating to the health and safety of the home and the safe recruitment of staff. We reviewed audits and governance processes and policies and procedures.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data and quality assurance records. We spoke with two professionals who regularly visit 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.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has now remained the same. 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 were not adequately assessed and mitigated.
- Information in risk assessments did not accurately describe people's current needs and how to reduce any risk. Where risks were identified, these did not always follow through into a care plan and staff were not always aware of how to support people who presented particular risks. For example, one person had been diagnosed with oedema (swelling in the legs and feet). There was no care plan in place to manage the condition and the diagnosis had not been considered when reviewing the skin integrity risk assessment. For another person, who was high risk of falls, any previous falls had not been considered as part of the risk assessment. Additionally, the person required mobility support from staff following a fall and injury and this had not been captured in the risk assessment or the care plan. Staff were supporting the person to mobilise in different ways which put the person at risk of harm.
- People who may require the use of bed rails to keep them safe while in bed were not safely risk assessed. We saw two examples of people using bedrails where the assessment was not appropriate and bed rails had been used which could have caused further risk of harm to each person.
- Staff told us they were informed in staff meetings and handovers about the risks people presented. However, they could not always describe how people were safely supported with mobility, the use of bed rails and the management of falls.
- Prior to the inspection, we requested and then reviewed risk assessments and care plans in relation to the serious incidents currently under investigation and found concerning information where people at risk of falls had not had their fall's risks adequately assessed, monitored and reviewed.
- At the last inspection, we found Personal Emergency Evacuation Plans (PEEPs) did not contain information for staff about how to support people to leave the building in an emergency. At this inspection, we saw the PEEPs had been updated but found further discrepancies, for example, one person was now bed bound and the PEEPs stated they could transfer with a zimmer frame and the support of two staff.
- Internal and external health and safety checks were completed by competent people.

People's safety was put at risk as risk assessments and care plans were not robustly completed or reviewed. This was a breach of Regulation 12, Safe care and treatment, of The Health and Social Care 2008 (Regulated Activities) Regulations 2014.

Learning lessons when things go wrong

- Accidents and incidents were reported and recorded.
- More recently, information around recent falls had been collated but there was no clear evidence any learning had resulted from this which contributed to people being safety supported.

● No learning had been identified from the previous falls which resulted in people being injured. There had been no analysis of these incidents to prevent similar incidents from occurring.

The provider did not do everything reasonably practical to learn from incidents and demonstrate people were receiving safe care and treatment. This was a breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment
● Rotas showed consistent staffing levels across both floors. Regular agency workers were used to cover vacant nurse and care worker shifts. Some agency workers received an induction to the service, but we could not be assured all agency workers completed the induction and were able to read care plans and risk assessments to have the knowledge to safely support people.
● We received mixed comments about agency staff usage from the permanent members of staff at the home. Some staff said the agency workers were fine to work with and one staff member commented, "I don't like working with agency staff, I have to constantly tell them what to do."
● People living at the home did not raise any concerns about staffing levels. Comments included, "There seems to be enough staff" and "There are not so many staff at night, they do check on you though."
● Staff felt staffing levels were sufficient at the time of inspection as the home had low occupancy, however, felt they would need reviewing when more people move into the home. Staff told us they needed a staff member in the communal lounge at all times, but this was not always practical as staff often needed to leave the floor to support people in their bedrooms or to obtain items from the other floor.
● Staff were recruited safely, and pre-employment checks were completed before employment commenced.

Preventing and controlling infection
● The provider had supported staff to understand guidance around the management of infection control, particularly in light of the current pandemic.
● Throughout the inspection, we saw staff using personal protective equipment and maintaining social distancing where possible.
● There was one occasion when a staff member did not wear a face mask when social distancing could not be maintained, we raised this with the registered manager who said they would discuss with the staff member.
● Staff told us personal protective equipment (PPE) had been continually available for them to use and we saw facilities for regular hand washing and sanitising stations.
● Staff had attended training in the management of COVID-19 infection risks and said they had been well supported during pandemic.
● People living in the home were supported to socially distance where possible and people admitted to the home during the pandemic had been initially isolated and supported in their rooms for recommended government timeframes to help prevent the spread of any infection if they had any.

Systems and processes to safeguard people from the risk of abuse
● People told us they felt safe in the home. One person told us, "Yes, I feel safe here." Family members confirmed their relative was safe while living at the home.
● Staff were able to describe processes in place to report any concerns they had and felt they would be acted upon. Staff had received safeguarding training.
●One staff member told us, "I know there has been safeguardings, but I haven't been made aware of what these are, I have no concerns to report to you."

Using medicines safely

- Medicines were safely managed across the home.
- There had been improvements in the storage of medicines from the last inspection with a dedicated room for medicines storage and management on both floors.
- Medicines administration record (MARs) charts we reviewed were appropriately completed.
- Audits of medicines showed a good compliance with medicines management.

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.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to 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

- The provider did not have adequate quality performance and governance systems in place to monitor and improve the safety for people living at the home.
- Of the quality monitoring processes in place, these did not identify concerns which placed people at risk of harm. For example, one person who was independently mobile, was using bed rails while in bed. Audits of care plans and risk assessments had not highlighted this risk and put the person in danger of falling from height should they climb over the bed rail. We received mixed responses from staff about whether this person used bed rails with one staff member saying, "[Name] is at risk, they try to climb out of bed." There was evidence in daily notes, care plans and risk assessments that bed rails, were in use and this had not been captured as part of any audits. Following this, we raised the information with the registered manager who confirmed bed rails should not be used for the person and this was shared with staff and care plans and risk assessments were reviewed.
- Audits of other risks were not robustly completed and had not identified what we found on inspection. For example, one person admitted to the home had concerns related to their skin integrity which was highlighted on their pre-admission assessment. There was no further assessment of this condition and this was not highlighted as missing, as part of the care file auditing process. This put the person at risk of a deterioration in their skin integrity and there was no oversight of this being a risk to the person.
- Audits did not capture the lack of important information in people's risk assessments. For example, some scores of risks were not reflective of people's current needs and for one person, previous falls had not been considered when the falls risk assessment had been reviewed. This would have placed the person in a higher category of risk. A falls reduction plan was in place, but this was not dated, signed or reviewed and the audit had not identified this.
- There was no clinical oversight at the home and the deputy manager had resigned from the service over 12 months ago. We highlighted concerns over the registered manager's ability to manage the service without support and following our inspection, a clinical lead position was advertised. A compliance manager had also begun to support the home, along with the director of the organisation. We will continue to review this support for the registered manager.

The provider failed to ensure robust audits were in place to identify shortfalls in care plans and risk assessments and remedy them in a timely manner. This was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

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

● Following four serious incidents at the home, the provider had failed to undertake any learning and implement safe management strategies to manage people at risk of falls.

● A fall monitoring chart was in place which highlighted where falls had occurred and number of falls in the previous month. This showed that one person had had two falls the previous month and the document stated the falls risk assessment had been reviewed. On examining the falls risk assessment, we identified that it had not been reviewed as the monitoring chart had suggested, which meant no further learning was gained around the management of falls for the person.

● Staff told us they had been told they needed to monitor the lounge area at all times due to the previous falls in the service and while some staff said this was manageable, other staff said it was not. This was due to having to leave the floor to collect items from the ground floor or to support people in their bedrooms.

● Staff told us people were regularly checked while in their bedroom, but there was no evidence of how people in the communal areas were monitored, especially if staff were not monitoring the area. No falls management equipment such as chair sensors was used in communal areas to monitor or support people who were mobile and at risk of falling.

● Not all agency workers received an induction which meant we could not be assured staff on duty were fully aware of people's needs.

The provider had not undertaken any learning following four serious incidents at the home and had not mitigated risk to others. The provider had not assured themselves agency workers were aware of people's care needs. This was a breach of Regulation 17 (Good governance) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others

● The provider did not engage with people effectively to ensure care plans and risk assessments captured people's current needs.

● There was a lack of clinical oversight of people's mobility, risk of falls, skin integrity, nutritional and choking needs. There was no one working at the home taking onboard clinical responsibility for the management of these risks.

● Staff and agency workers were not always provided with the correct information of how to successfully support people in a safe and person-centred way.

● There was no evidence audits and reviews of people's care and support needs had identified care plans and risk assessments were not person-centred and did not accurately describe people's current needs.

The provider failed to highlight where care plans and risk assessments did not accurately describe people's current needs. This was a breach of Regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 monitored and responded to concerns received at the home and relatives we spoke with felt they could raise anything concerning and be responded to.

● Prior to the inspection, we had received concerns about the providers ability to respond to requests in a timely manner which included the sharing of documentation and answering calls to the homes phone.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider failed to highlight where care plans and risk assessments did not accurately describe people's current needs.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risk assessments did not adequately assess the risk people presented which placed people at further risk. Risk assessments were not robust and not always fully completed and lacked information and guidance to mitigate risk.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not have effective systems and processes to assess, monitor and improve the quality and safety of the service. The provider did not assure themselves that agency staff were aware of people's needs.