

G & A Investments Projects Limited

Oakwood Residential 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

Oakwood Residential Home is a residential care home providing personal care and accommodation for up to 28 people. The service provides support to older people and those who may be living with dementia. At the time of our inspection there were 23 people using the service. Accommodation was spread over two floors accessible via a lift.

People's experience of using this service and what we found

People told us they were happy and safe living at Oakwood Residential Home. We were told by people living in the service and their relatives that they felt included, safe and well cared for. The service was clean and well maintained. However, risks related to legionella had not been fully mitigated.

Risks to individuals were assessed when they started but we found they were not always up to date and reflective of their current needs. The registered manager worked well with other health-care professionals to ensure that learning took place and necessary changes were made to continually improve. However, this was not always reflected in people's care plans. We found that the provider had not been following their own falls procedure and there was no evidence of observations being made after a fall to monitor the person's condition for signs of deterioration.

People were supported safely and appropriately by sufficient staff who knew people well. However, not all staff had satisfactory evidence of conduct in previous employment in health or social care, with children or vulnerable adults. Staff training was not always complete or up to date although we did not observe any evidence of poor care during the inspection.

Processes and procedures were in place to store and administer medicines safely. We were somewhat assured appropriate infection prevention and control measures were in place to protect people against the risk of COVID-19 and other infections. However, wearing of masks in line with government guidance could have been better.

The registered manager felt they were not well supported by the provider and needed more support to ensure training was up to date. The staff team told us they felt supported by the registered manager. People who used the service and staff were involved in how the service was managed. The registered manager had processes in place to monitor and improve the quality of the service people received.

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 19 May 2018).

Why we inspected

This inspection was prompted by a review of the information we held about the service.

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.

This report only covers our findings in relation to the key questions safe and well-led. 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 has changed from good to requires improvement. This is based on the findings at this inspection.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Oakwood Residential 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 and will take further action if needed.

We have identified breaches in relation to managing risks to people, the risk of legionella, staff recruitment practice and training at this inspection. We found that the two areas reviewed were now rated as requires improvement.

Follow up

We have requested 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 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 always safe.

Details are in our safe findings below.

Requires Improvement ●

Is the service well-led?

The service was not always well-led.

Details are in our well-led findings below.

Requires Improvement ●

Oakwood Residential 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 Health and Social Care Act 2008.

As part of this inspection we looked at the infection control and prevention measures in place. We did this to 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

Two inspectors and one Expert by Experience carried out this inspection.

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

Oakwood Residential Home 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. Oakwood Residential Home is a care home without nursing care. The Care Quality Commission (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 CQC 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

This inspection was unannounced.

Inspection activity started on 24 August 2022. We visited the service on 24 and 25 August 2022.

What we did before the inspection

The provider was not asked to complete a Provider Information Return (PIR) as part of this inspection. A PIR is information providers send us to give some key information about the service, what the service does well and improvements they plan to make.

We reviewed information we had received about the service since the last inspection. This included notifications of events providers are required to tell us about, and information from members of the public about their experience of the service.

We used all this information to plan our inspection.

During the inspection

We spoke with six people and nine relatives of people who used the service about their experience of the care provided. We spoke with the registered manager and five members of staff. We also spoke with four professionals involved with the service.

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

After the inspection

We continued to seek clarification from the registered manager to validate evidence found. We looked at records sent to us by the registered manager. These included training records, quality audits and fire risk assessment.



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 good. At this inspection the rating has changed 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

- The provider had not taken full account of the risk of legionella, a potentially fatal infection. Legionella can cause a serious type of pneumonia called Legionnaires' disease. Although there had been a risk assessment in 2020 there was no evidence of actions required from this being completed. There were no regular pre tap temperature checks or flushing of little used outlets. There was checking of water outlets for the presence of legionella carried out by an external company. These had come back as negative for the bacteria; however, this was not in line with current guidance so we could not be assured the provider had taken sufficient steps to protect people from the risk of legionella. During the inspection the registered manager told us they would get another external risk assessment to check if the previous work had been completed.
- We reviewed incident reports and found that the provider had not been following their own falls procedure and there was no evidence of observations being made after a fall. This included one incident which involved a person sustaining a head injury. Although appropriate medical attention had been obtained at the time of the incident, the registered manager was unable to show us what actions had been taken afterwards to monitor the person's condition for signs of deterioration.
- Risks to individuals' safety were assessed when they started but we found they were not always up to date and reflective of their current needs. This meant that people were potentially at risk of harm from poor care although we did not observe this during inspection. The provider had processes in place to mitigate risks such as those associated with falls, skin integrity and medication but these were not always reflected in their care plans.

The failure to ensure risks were fully assessed and mitigated was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Other health and safety checks of the building were completed effectively with documented maintenance records. Maintenance and repairs were carried out by a dedicated person at the home.
- Fire risk assessments were completed and equipment for use in the event of a fire was available and serviced in line with requirements. People had individual evacuation plans in the event of an emergency where they had to leave the home. After the inspection the registered manager provided an updated external risk assessment with minor actions to complete.

Staffing and recruitment

- Staff training was not always complete or up to date. Staff had not completed mandatory training or it had lapsed. The registered manager told us it was difficult to get staff to complete their training online as they were expected to complete this at home unpaid. One relative told us, "Some of them (staff) seem to be

trained a lot, others are not so clued on." Following the inspection, the registered manager arranged for some staff that did not have moving and handling training to have practical training at another provider service. The provider needs to put in place a system to ensure staff have the incentive to complete the training required to support people safely.

There was not a robust effective system in place to ensure that the provider employed people who were suitably qualified, competent and experienced. This placed people at risk of receiving inappropriate or unsafe care. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The provider made pre-employment checks to new staff to help ensure their suitability for the role. These included Disclosure and Barring Service (DBS) checks, which provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions. However, not all staff had satisfactory evidence of conduct in previous employment in health or social care, with children or vulnerable adults. Staff had started to work with people before these assurances were obtained. The provider had either not asked for this or was waiting for a reply. Half of the files we looked at also had gaps in employment history. We discussed this with the registered manager who said it was difficult to get references from other care organisations. The provider needs to have a process in place to meet the requirements of the legislation.

There was a failure to have robust effective recruitment to ensure that staff were of good character and had the qualifications, competence and skill to carry out care and support appropriately and safely. This was a breach of regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- People were supported by sufficient numbers of staff to meet their needs and keep them safe. The registered manager had increased the number of staff on shift to ensure this. Most relatives we spoke with told us they felt there were enough staff.
- We observed good interactions between staff and people they supported. We did not observe any evidence of poor care during the inspection. One relative told us, "Certainly care wise they have always been good."

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. Consent to care had been obtained by the provider and this was recorded in the person's care plan. Staff were observed obtaining consent before administering medication.
- Best interest decisions had been made where required. Where the decisions were more significant such as end of life care, the provider had ensured that all the appropriate people were involved in the decisions made.

Using medicines safely

- People received their medicines safely and in line with their prescription. Processes were in place to seek GP guidance if a person needed their medicine in a different format such as liquid rather than tablet to make it easier for them to swallow.
- Staff who administered medicines were appropriately trained. Medicines records were complete and up to date. Staff we spoke to knew the medication needs of the people they supported well. Relatives told us they had no concerns regarding medicines. One relative told us, "His medication is given regularly, there has never been any problems. They always give me the right pills when he comes home here."
- There were appropriate guidance and protocols in place for people's medicines, including for medicines to be taken "as required" (PRN). Staff managed and stored people's medicines safely and securely.
- We observed staff administering medicines safely with appropriate and dignified interaction with people. Where one person had refused their medicine, it was correctly recorded on the medication administration record. Although no harm had come to people, we did find that staff were not always following up to check if missing medicines would cause any harm. We advised the registered manager of this during the inspection who took this on board.

Systems and processes to safeguard people from the risk of abuse

- People were safe and safeguarded from abuse in the home. All the relatives we spoke with were very confident that people were safe and well cared for by staff. One relative said, "I've no concerns with that regard (safety)." Another said of their relative, "She is safe there, they are really good."
- Staff were aware of the risks of abuse and poor care, and what to do if they were to witness or suspect instances of abuse. Relatives told us that they or their relatives were confident if they were to raise a concern it would be dealt with appropriately.
- The provider had suitable policies and processes to keep people safe, however it was not clear when they were last reviewed to ensure all the information within remained current. Some staff we spoke to were also unclear as to what the whistleblowing procedure was. We discussed this with the registered manager who said they would address this.

Preventing and controlling infection

- The provider managed the control and prevention of infection in the service. The home appeared clean and tidy with no malodours.
- Processes and procedures were updated in line with COVID-19 requirements. Relatives told us they felt the home was always clean, tidy and well maintained.
- We were assured that the provider was preventing visitors from catching and spreading infections.
- 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 somewhat assured that the provider was using personal protective equipment effectively and safely. We observed that not all staff were following the current guidance on mask wearing. We discussed this with the registered manager who said they now had the latest government guidance to follow.
- We were assured that the provider was accessing testing for people using the service and staff.
- We were assured that the provider was promoting safety through the layout and hygiene practices of the premises. There was a check list of what needed to be cleaned and when, which staff used.
- 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.

We have signposted the provider to resources to develop their approach.

- The provider allowed visits to the care home in line with government guidance.

Learning lessons when things go wrong

- Accidents and incidents were reported. There was a process in place for the registered manager to review the reports, but it was not always clear if this had been followed or what actions were taken to reduce the risks to people. The registered manager had worked with other health-care professionals where necessary.

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 good. At this inspection the rating has changed 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

- The registered manager and other staff felt that they could be better supported by the provider. This would enable the registered manager to ensure that the service complies with the regulations. For example, better support to ensure training is up to date. The registered manager did not have a contract that reflected her position. Having an appropriate contract would help to understand the requirements of the job role. The registered manager would also benefit from having better supervision and support from their line manager.
- Staff were guided to provide appropriate care by the provider's policies but could not always remember when they had last read them. Those we checked were relevant, however, it was not always clear when they had last been reviewed to ensure they remained in line with best practice.
- The provider had not supplied an updated statement of purpose to CQC since first registration. After the inspection the registered manager sent us their current version which needed to be updated. The registered manager told us they would ensure this was up to date and sent through to CQC.
- Staff were clear about their roles, they were familiar with the people living in the service and supported them safely and appropriately. There had been a new deputy manager appointed which the registered manager said would help going forward.
- The registered manager was aware of reporting requirements to CQC and other organisations, including new ones which had been introduced during the COVID-19 pandemic. The registered manager had arranged with the local GP surgery to provide regular practice nurse engagement.

Continuous learning and improving care

- Audits of various aspects of the service were detailed and carried out by the registered manager. The audits identified issues that needed to be addressed and covered most aspects of the service such as care plans, health and safety, and fire. Although audits had not been happening consistently previously, they were now being done regularly. The registered manager carried out audits of various elements of the service monthly and should ensure these remain robust and effective to improve the quality of care in the service.
- However, robust legionella checks were not included in the regular audit which had resulted in the risk not being managed in line with guidance. In addition, staff files had not been audited recently which had also resulted in some missing information not being identified. We raised this with the registered manager who would look to address this.
- The registered manager reviewed processes and involved other health-care professionals in response to incidents and accidents to ensure that any improvements in the care delivered were identified and actioned.

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

- There was positive feedback about the registered manager and staff team. Relatives said they knew who the registered manager was and that they were approachable, and easy to talk to. One person told us that the, "Staff are superb". Relatives said the registered manager was, "Very helpful, on the ball. She has answered any questions I've asked" and "I feel able to raise concerns. She is approachable and listens."
- The registered manager worked well with people, their relatives and staff to create a friendly and open atmosphere in the service. The feedback from people and their relatives was very positive, all felt safe, well cared for and included within the service.

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

- People had a good relationship with the registered manager. People's relatives told us they could raise concerns and had full confidence they would be dealt with. The registered manager was aware of the need to be honest and transparent in the event of certain notifiable events.

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

- People who used the service and their families were involved in changes in the service. People supported by the provider had been supported to fill in a survey about their care, and those that we saw were positive. Relatives we spoke with said they hadn't been asked for feedback or attended a residents' meeting. One relative told us, "I've never had a questionnaire". However, they also said staff would listen to them if they had any feedback about the running of the home. During the inspection the manager said she was looking to arrange residents' meetings in the future.
- People's diversity was considered to ensure they were supported appropriately. This was recorded in their care plans by staff.
- There were staff meetings where staff were encouraged to raise concerns or ideas for improvement. This had been working well, and the minutes we saw were detailed with good staff attendance. The registered manager told us that they planned to have meetings every two months and that they were arranging a separate meeting to enable night staff to attend.
- Records showed that staff supervisions were not always happening regularly for all staff. Supervisions are opportunities for two-way conversations. However, staff told us they felt supported and could take concerns to the management team at any point. The registered manager was aware of this and told us they would arrange more regular supervision for staff by their line manager. The registered manager had been recording where they had talked with staff in a "touchpoints" spreadsheet which worked well.

Working in partnership with others

- The registered manager was open and transparent when working with other agencies and healthcare professionals to deliver joined-up care for people. The registered manager had been working with the local quality and safeguarding team which offered good support for the service in improving their quality of care.
- The registered manager had a good working relationship with other visiting health care professionals such as district and practice nurses. There was also positive feedback from visiting professionals that we spoke with.

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	<p>Regulation 12 HSCA RA Regulations 2014 Safe care and treatment</p> <p>The provider had failed to ensure risks were fully assessed and mitigated. This is a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.</p>
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	<p>Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed</p> <p>There was a failure to have robust effective recruitment to ensure that staff were of good character and had the qualifications, competence and skill to carry out care and support appropriately and safely. This is a breach of regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.</p>
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	<p>Regulation 18 HSCA RA Regulations 2014 Staffing</p> <p>There was not a robust effective system in place to ensure that the provider employed people who were suitably qualified, competent and experienced. This placed people at risk of receiving inappropriate or unsafe care. This is a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.</p>

