Rushcliffe Care Limited

Oakford Manor Nursing Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Oakford Manor Nursing Home is a residential care home providing accommodation for people requiring personal and nursing care to 28 people aged 65 and over at the time of the inspection. The service is registered to support up to 50 people. There were eight 'companion rooms' but these were not being used at the time of the inspection, everyone living there had their own bedroom. The building is set over two floors, during the inspection the ground floor bedrooms were used by people receiving nursing and personal care, people receiving assistance with only personal care lived in the upstairs bedrooms.

People's experience of using this service and what we found
People were at risk of harm because the provider had not always assessed risks to people's health and safety or done all that was reasonably practicable to mitigate risk, including those which were healthcare related. The provider did not ensure there were always enough suitably qualified staff to give people the support they needed.

The provider did not follow or meet national guidance in relation to infection prevention and control for the Covid-19 pandemic. This put people and staff at risk. The provider had not introduced procedures to detect and control the spread of infection during the Covid-19 pandemic. Staff did not always wear or have access to appropriate Personal Protective Equipment (PPE).

People were at immediate risk of avoidable harm because of the way they were supported to move. Some unsafe practices were used. When things had gone wrong, the provider did not always learn from events or take action to improve safety.

There were widespread and significant shortfalls in the way the service was led. Staff told us the service was not well-led. Staff said they feared repercussions from speaking with us and told us there was a blame culture. Quality assurance arrangements were not applied consistently. There was little evidence of learning, reflective practice or service improvement.

The home was clean and free from malodours and medicines were safely managed.

Rating at last inspection – The last rating for this service was Good (Published May 2018).

Why we inspected
We received concerns in relation to infection prevention and control and the way staff assisted people to move. As a result of this and other information we had received, 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. We completed a risk assessment relating to the Covid19 pandemic that was ongoing at the time this inspection was completed. Ratings from previous comprehensive inspections for those key questions were

used in calculating the overall rating at this inspection.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe. And there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it, and no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Oakford Manor Nursing 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 discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to safe care and treatment, governance and staffing at this inspection. We have served a Warning Notice against these Regulations. We have told the provider we require them to be compliant in these Regulations within 12 weeks of receiving our Notice.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not 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.

Oakford Manor 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.

Inspection team
This inspection was carried out by two inspectors and two assistant inspectors.

Service and service type
Oakford Manor Nursing Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service did not have a manager registered with the Care Quality Commission. The previous manager had not registered with CQC, the new manager had been recruited and started their role between the first and second days of our inspection visits. A registered manager and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced.

What we did before 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 with

key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections. We used all of this information to plan our inspection.

During the inspection
We spoke with three people who used the service and four relatives about their experience of the care provided. We spoke with 18 members of staff including the area manager, compliance manager, nurses and care staff.

We reviewed a range of records. This included five 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 policies and procedures were reviewed. In between day one and day two of our inspection we sent a letter to the provider instructing them to make immediate improvements in the management of infection prevention and control in relation to the Covid-19 pandemic. We reviewed this on day two of the inspection and saw it had been completed.

After the inspection
We continued to seek clarification from the provider to validate the evidence we found. We instructed the provider to review some policies and procedures to improve safety for people and staff. The provider responded to us within the given timescale and reassured us of the improvements they had implemented. We looked at training data and quality assurance records. We spoke with four professionals who regularly visit the service.

Inadequate

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 deteriorated to Inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management

At our last inspection we recommended the provider sought advice from a reputable source about the assessment and management of risk. At this inspection we found there were further improvements required in this area.

- The provider had not always assessed risks to people's health and safety or done all that was reasonably practicable to mitigate risk. For example, where people had health conditions that increased their risk of illness, these risks were not explored, and plans were not in place to reduce the risk of avoidable harm.
- We reviewed risk assessments in care plans and found where they had been completed, some were generic and not always reflective of the needs and preferences of the person.
- Staff told us they did not know what was written in risk assessments and therefore were not always supported to understand how to keep people safe. One staff member said, "We're supposed to read risk assessments but none of us do, we wait until someone tells us at handover." Another staff member said, "Risk assessments are in the files, but care staff don't look at those." A different staff member said, "We do the best we can, no-one tells anyone about risk, we have to try to work it out for ourselves."

Preventing and controlling infection

- The provider did not follow or meet national guidance in relation to infection prevention and control for the Covid-19 pandemic. This put people and staff at risk. The provider had not introduced procedures to detect and control the spread of infection during the Covid-19 pandemic.
- The provider did not ensure staff were provided with, or had access to the most up to date national guidance in relation to the spread of Covid-19 and how staff should help to prevent this. For example, there were two signs up on one wall, one advised staff to wear a surgical mask at all times, another advised staff to wear surgical masks in people's bedrooms but not in the corridors.
- Staff told us they did not feel they were provided with support to understand and follow national guidance in relation to the prevention and control of infection. One staff member said, "There is confusion and complacency around the wearing of PPE." Another staff member said, "I've noticed care staff aren't always wearing PPE, we're not sure what we should do and shouldn't do." A different staff member said, "We're not supposed to wear our uniform to go to and from work, most staff still do though, no-one checks."
- One person living there was supported to have a medical procedure which increased the risk of the spread of infection. National guidance was not followed to protect people living in close proximity to this person from the potential spread of infection from inhaling the particles this procedure created.

● Throughout the inspection visit, we saw many occasions where staff were not wearing the appropriate PPE. This placed people at risk. For example, we saw staff not wearing surgical face masks, staff not wearing disposable gloves or aprons and staff wearing surgical face masks that were pulled down underneath their chin, therefore not offering any protection.
● We observed staff did not routinely adhere to social distancing. At the time the inspection was carried out, national guidance was for people to remain two meters apart wherever possible. However, we saw staff did not observe social distancing when supporting people. We observed an activity where 16 people and five staff were in the main communal lounge. There was enough space for the activity to be completed whilst observing social distancing, but people were in close proximity to each other and staff were not always wearing PPE.

Systems and processes to safeguard people from the risk of abuse
● People were at immediate risk of avoidable harm because of the way they were supported to move. One person had been assessed as requiring a full body hoist with a minimum of two staff to assist them to move. Staff had told us before and during the inspection that this person was regularly moved without the use of the hoist. Staff told us they used a technique they called 'bear hugging' (also known as drag lifting). One staff member told us, "[Name] is active in the hoist so it's dangerous, we lift [Name] ourselves with two of us." Another staff member said, "We know [Name] should be hoisted but staff cut corners because they're so busy, so most people lift [Name]." A different staff member told us they didn't think [Name] had a hoist sling and they'd always lifted [Name].
● The provider was aware this person had been supported to move in an unsafe way, the manager had left notes on handover documents reminding staff to use the hoist and not to 'bear hug'. However, the provider had not identified the reason staff were not using the hoist and had not re-assessed the person's needs or provided staff with support to maintain this person's safety. This placed people at risk of abuse, and they could have been hurt by the unsafe practices used to assist them to move.

Learning lessons when things go wrong
● When things had gone wrong, the provider did not always learn from events or take action to improve safety.
● During the Covid-19 pandemic a high number of people and staff had contracted the virus. The provider had failed to assess potential reasons for this or implement improvements to prevent this happening again. For example, a staff member had sought advice from an external healthcare professional about the lack of PPE and not adhering to guidance issued by Public Health England (PHE). The manager employed at the time had admitted the error and assured the healthcare professional that they would adhere to national guidance from there on. However, when we conducted the inspection 10 weeks later, there was still a lack of up to date guidance in relation to the Covid-19 pandemic.

The provider had failed to assess of risks to the health and safety of service users, actions had not been taken to do all that was reasonably practicable to mitigate risks to service users, including in the prevention, detection and control of the spread of infections that were health care related. This placed people at risk of harm. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Immediately after the inspection we contacted the provider to highlight our concerns and requested they investigate and provide us with reassurances that safe practices had been implemented with immediate effect. The provider did respond to us within the given timeframe and provided reassurances including photographic evidence of the improved practice in place. We then conducted a second day of inspection to ensure these processes were still being used. They were and we were reassured that improvements had

been implemented.

● Assisting a person to move in an unsafe way is a safeguarding concern and as such, should be referred to the local authority safeguarding team. This had not been done. Other incidents that could be considered a safeguarding concern were referred and investigated.
● Throughout the inspection the home was clean, tidy and free from malodours.

Staffing and recruitment

At our last inspection we recommended the provider found out more about the deployment of staff including where people had specialist needs. At this inspection we found there were further improvements required in this area.

● The provider did not ensure there were always enough suitably qualified staff to give people the support they needed. Relatives we spoke with told us there were rarely enough staff. One relative said, "There just never seemed to be enough staff there." Staff we spoke with told us there weren't enough staff. One staff member said, "Staffing is a bit dodgy, it's hit and miss if there are enough staff or not." A different staff member said, "There is a lot of staff sickness, it's because staff are so overworked." Another staff member said, "We are short staffed and it's a safety issue."
● We reviewed rotas and staff signing on sheets and found there were not always enough staff on duty to keep people safe. For example, we found night shifts where there were only two or three staff on duty and one shift where there was only one staff member recorded to have been on duty. The provider had documented that four staff were required on night shifts.
● The provider's statement of purpose stated required staffing levels on day shifts were calculated by the dependency of the people living there and were regularly reviewed. However, it also stated there would always be four members of staff on duty between the hours 20:00 and 08:00, this was irrespective of the number of people living there or the complexity of their needs. This showed the provider did not assess the number of staff required on night shifts to meet people's needs or respond to emergency situations such as people becoming acutely unwell or a fire.
● Staff were not always up to date with safety related training. We reviewed the provider's training matrix and found some staff had been working without safeguarding or infection prevention and control training. This put people at risk of being supported by unqualified staff.

The provider had failed to ensure the deployment of suitably qualified, skilled and experienced staff. 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 reviewed the provider's recruitment policy and staff records and found people had been safely recruited. Pre-employment checks such as criminal records checks, and references were completed.

Using medicines safely
● Staff managed medicines consistently and safely. Medicines were received, stored, administered and disposed of safely. This included where medicines were prescribed, taken as and when required and homely remedies, such as over the counter medicines and creams.
● We reviewed medicine administration records and found these to be completed as per national guidance. There were protocols for medicines taken as and when required and when creams or patches were applied to skin there was documentation to show where on the person's body these had been applied.

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.

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

- There were widespread and significant shortfalls in the way the service was led. Staff told us the service was not well-led and there were high levels of stress and an unmanageable workload. One staff member said, "I think the lack of leadership is the underlying problem at Oakford Manor." Another staff member said, "It's the senior management, they don't let managers get on with what they are supposed to do, and managers leave, staff cut corners because they can't do everything they are expected to do." A different staff member said, "We just get shouted at for things, I wouldn't call that support."
- Staff told us they did not feel listened to, valued, supported or respected. Staff said they were frightened of speaking with us because they felt there was a blame culture and senior management would discipline anyone who raised concerns with us. One staff member said, "I've given up hope about giving the standard of care I want to give, year after year there is an acceptance of the low level of staff, they just tell us it's OK, but it isn't."

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

- Management and staff did not understand the principles of good quality assurance and the service lacked drivers for improvement. The service did not have a manager that was registered with CQC and senior managers did not have oversight of the service. There had been two managers in the previous 11 months. Staff told us the inconsistent management meant it wasn't always clear what they should or shouldn't do. One staff member said, "Best practice is completely bypassed because we're not sure what we should do." A new manager started their employment between the first and second days of inspection.
- Before the inspection we conducted an 'Emergency Support Framework Call' with the previous manager. They provided assurances about the safe practices in respect of the Covid-19 pandemic. They were not open and honest about a whistle-blowing concern received by the external healthcare professional, and we found the assurances they had provided us about infection prevention and control were not in place when we arrived for this inspection. The improvements noted to be in place when the provider submitted their PIR in February 2020 were also not in place. This showed a lack of monitoring and transparency. The provider had not identified or addressed this.
- Analysis, audits and governance had not been completed as per the providers policy. The previous manager had informed us they had not had time to do this during the Covid-19 pandemic. However, this

task had not been taken on by the provider nor had they delegated this to anyone else within the senior management team. This meant there was a lack of oversight between January and July 2020 and no attempt was made to identify risk or check to see if national guidance was followed.

● Legal requirements were not always met. For example, rotas and staff signing on sheets which are required by law to evidence how many people are in a building at any one time were not always dated or legible. This meant the provider was not always aware of how many staff had been on duty.

Continuous learning and improving care

● Quality assurance arrangements were not applied consistently. There was little evidence of learning, reflective practice or service improvement. The senior management team had not identified the risks to people's safety or lack of staff knowledge, understanding and following of national guidance in relation to the Covid-19 pandemic. Management were aware staff were using unsafe practices in relation to moving and handling but had not implemented processes to support staff to change this.

● The provider had implemented policies in relation to the Covid-19 pandemic, though these were last updated in March 2020 so did not reflect the current guidance. Immediately after the inspection the provider assured us they had implemented new updated policies for this.

The provider had failed to effectively implement systems to assess, monitor and improve the quality and safety of the care provided. This placed people at risk of harm. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Working in partnership with others

● The service had, as with all other homes at the time, been closed to visitors due to the Covid-19 pandemic. This meant that external professionals such as the local authority and clinical commissioning group had not been present in the home as they normally would. Both organisations told us the manager in place before the inspection would contact them and share any information that was asked for. Immediately after the inspection we were informed the provider was working with infection control professionals to drive forward improvements noted to be required at this inspection.

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 didn't always adhere to the duty of candour. Relatives told us they always received a phone call if their relation had had a fall. However, we did not see evidence of open and honest communication with the relatives of the person who was assisted to move using unsafe techniques. Referrals were made to the local authority, clinical commissioning group and healthcare professionals.

● The provider is legally required to notify CQC when certain events have happened. We checked and saw these had been submitted appropriately.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

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 The provider had failed to assess of risks to the health and safety of service users, actions had not been taken to do all that was reasonably practicable to mitigate risks to service users, including in the prevention, detection and control of the spread of infections that were health care related. This placed people at risk of harm.

The enforcement action we took:

warning notice

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 had failed to effectively implement systems to assess, monitor and improve the quality and safety of the care provided. This placed people at risk of harm.

The enforcement action we took:

warning notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had failed to ensure the deployment of suitably qualified, skilled and experienced staff. This placed people at risk of harm.

The enforcement action we took:

warning notice