Barchester Healthcare Homes Limited

Oulton Park Care Centre

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Oulton Park Care Centre is a care home registered to provide personal and nursing care to 60 older people across two units.

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

Whilst people using the service told us they felt safe, we found that the service did not always have clear and robust measures in place to reduce the risks to people. Where risks had been identified, there was not always appropriate care planning in place to guide staff on how those risks should be reduced. Where care plans were in place, these had not always been followed and this had not been identified by senior staff.

The numbers and deployment of staff meant that people did not always receive support from staff when they required it, either to keep them safe or to ease emotional distress.

Not all of the shortfalls we found had been identified in audits by the service. Despite concerns being raised by staff about the staffing level, improvements had not been made by the time of our visit.

The management and oversight of the service had not been effective, as the quality of the service had deteriorated since our previous inspection on 11 December 2019. The service had struggled to recruit and retain a consistent manager during this time.

People did not have access to sufficient sources of meaningful engagement and were at risk of social isolation.

People received sufficient support to eat their meals. However, observations identified that people did not always have drinks available to them.

The environment was safe and appropriate checks were carried out to identify risks in the environment. Infection, prevention and control procedures were implemented effectively across the service.

Improvements had been made in the management and administration of medicines. These were now managed and administered safely.

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

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

Rating at last inspection
The last rating for this service was 'Requires Improvement' (Report published 1 April 2020). At this inspection enough improvement had not been made and the provider was in breach of further regulations.

Why we inspected
The service was rated 'Requires Improvement' at the last inspection and we needed to check whether the improvements had been made.

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.

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

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 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 managing risks to people, ensuring appropriate staffing levels, ensuring person centred care is delivered and ensuring good governance and oversight of the service at this inspection.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

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 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 it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

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 responsive?

Inadequate

The service was not responsive.

Details are in our safe findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our safe findings below.

Oulton Park Care Centre

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 this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
This inspection was carried out by two inspectors and an Expert by Experience.

An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
Oulton Park Care Centre 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.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed all the information we had received about the service since our previous inspection. We attended meetings with Suffolk County Council and gathered information about concerns they had about people's safety and welfare.

During the inspection

We spoke with four people who used the service, five relatives and two friends of people using the service about their experience of the care provided. We spoke with 11 members of staff including the managing director, registered manager, senior care workers and care workers.

We reviewed a range of records. This included 10 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 sought further information from the provider about how they were addressing the most serious concerns we identified during our visit. We had further conversations with Suffolk County Council and the Clinical Commissioning Group following their subsequent visits to the service to share information.

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

● People were not always protected from the risk of injury caused by other service users. There had been six incidents between two people since 19 January 2021, and we observed one of these people had injuries which staff told us had been caused by the other person. Despite these incidents we observed these people being left together unsupervised for long periods of time and on occasions they were showing agitation towards each other. Staff were not present to observe them and reduce the risk of further incidents. One of these people had also caused injury to other service users on three occasions in May and June 2021. Despite this care planning did not make clear how the risk of them causing harm to others was being minimised.

● People were not always protected from identified risks because staff did not follow care planning. For example, one person was at very high risk of strangulation, but staff had not followed the care planning to ensure wires were hidden and they were left unsupervised for long periods of time. Staff had also not followed this persons care plan to ensure they were supervised when eating and drinking, as we observed they were left alone for an extended period of time with a bowl of food and a drink. They were also in an area where there were solid foods, they could access even though they were on a soft diet due to their choking risk.

● Care plans were not always clear when people were at risk of choking and did not always accurately reflect the support they needed to reduce this risk. For example, one person's nutrition care plan stated they were at low risk of choking, but they were described in their Suffolk County Council care assessment as being at high risk of choking and they were on a modified diet as a result of this. Another person's choking risk assessment stated they could have fluids of a normal consistency, when they required thickened fluids to reduce the risk of choking. Another person had episodes of choking in the past and was on soft diet and thickened fluids, but their choking risk assessment still stated they were at low risk of choking. This did not accurately reflect their risk level and could cause confusion for staff.

● People using the service were not always protected from risks in the environment. On the unit for people living with dementia we noted risks that had not been considered. For example, in the communal dining area there was access to cutlery such as knives, a hot water kettle providing hot water on demand and solid foods when many people required a soft diet. All of these items could be accessed by people and we observed staff were not present in this area for extended periods of time. In addition, tubs of drink thickener were present in an unlocked low-level cupboard. If these powders are ingested without being diluted in drinks, they can pose a choking risk.

● We fed back these concerns at the end of our inspection visit, and we were sent a written response which confirmed action had been taken to address the above concerns. This included putting in place one to one staff to better supervise people who had frequent episodes of emotional distress and to ensure the risk of strangulation to one person was reduced.

Learning lessons when things go wrong
● Incidents and accidents were recorded, and the manager carried out an analysis of these on a monthly basis.
● Actions had been taken in response to incidents, for example, referrals were made to the Dementia Intensive Support Team for one person. However, this did not always lead to robust plans being put in place to reduce the risk of recurrence.

Systems and processes to safeguard people from the risk of abuse
● The service had not always responded appropriately to reduce the risk of people using the service causing harm to other people. The staffing level had not been calculated in a way which allowed for supervision of people who were known to have caused injuries to others during periods of emotional distress. This meant people were not always protected from the risk of being injured by others.

● Staff had an understanding of safeguarding, the different types of abuse and their responsibility for protecting people.

This was a breach of Regulation 12: Safe Care and Treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment
● There were not sufficient numbers of staff deployed to support people at the time they required it, to provide adequate supervision and to reduce the risk of people becoming socially isolated. We spoke to four people living on the nursing unit who all told us there were not enough staff and they had to wait for support. One said, "Sometimes they do take a long time to answer the buzzer." Another person told us, "They could do with more staff; the staff are very busy." Relatives also raised concerns about the staffing level. One said, "They seem to take long to get to people when they call them, the residents always seem to wait a long time for someone to come". Another told us, "[Relative] did complain that they had to wait, on occasions, after 10.30am for staff to get them washed and dressed." Staff made negative comments about the staffing level and told us they had raised this with the registered manager on repeated occasions. Three staff members described the staffing levels as 'unsafe'.

● Comments made by people using the service, relatives and staff supported our observations that there were not enough staff to support people. This was more evident on the unit for people living with dementia, some of whom displayed distressed behaviours and required regular emotional support. We observed people using the service were left for extended periods of time without staff being present in the area or checking on them. We observed during these times that staff were very busy and were supporting other people who required care in their bedrooms or other parts of the unit. We observed people did not have drinks available to them and at one point, a person came in and was looking for something in a kitchenette area. They then went and took another person's drink and drank it, so it's possible they were thirsty and had no access to drinks. On the nursing unit, we observed one person who required support with their meal but the only staff member available was supposed to be providing one to one care to another person. During the inspection people frequently came up to us distressed, wanting to talk or needing help with something but we could not find available staff to support them. Despite the activities coordinator having left, the

registered manager had not deployed more staff to engage people. One person said, "I just sit here in a corner all day."

This was a breach of Regulation 18: Staffing of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● When we fed back concerns about staffing, we were told the staffing level would be reviewed by senior staff. Following this, they confirmed that further staff were deployed to ensure people's needs were met. The managing director also told us they were reviewing the dependency of people using the service against the skill set of the staff to ensure that they could meet their needs effectively.

Using medicines safely
● At the previous inspection, we found that medicines were not always managed and administered safely. At this inspection we found improvements had been made. We carried out an audit of people's medicines on both units, comparing the stocks of remaining medicines with the medicines administration records (MARs). We found that these matched, indicating people received their medicines as prescribed. People who had time sensitive medicines received these at the frequency required.

● Audits were carried out of medicines administration and further oversight had been implemented following the shortfalls identified at the previous inspection. This had been effective in ensuring improvements were made and sustained.

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

● We were assured that the provider was meeting shielding and social distancing rules.

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

● We were assured that the provider was accessing testing for people using the service and staff.

● 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 also signposted the provider to resources to develop their approach.

Inadequate

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs

At the last inspection the service was rated 'Requires Improvement' in this key question. At this inspection we found that improvements were still required, and the service is now 'Inadequate' in this key question. This meant services were not planned or delivered in ways that met people's needs.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

● People told us that there were not sufficient activities or sources of meaningful engagement available to them, and this confirmed our observations. One person said, "The lack of activities make you feel isolated". Another person said, "I get bored all the time, nothing to do, I feel sorry for myself".

●The registered manager told us that the main member of activities staff had resigned, and they were currently recruiting. This left one other staff member who provided 22 hours of activities a week across both units. However, the registered manager had not deployed additional care staff in order to support people with remaining engaged and to reduce the risk of social isolation.

● We observed that people on both units were disengaged and largely left alone during our inspection with little contact from staff. On the dementia unit, people walked around the home and picked up items like CD's but there were no more suitable items for them to access independently. People living with dementia can benefit from having free access to 'tactile items' or sensory items. These can be things like soft toys, items with different textures or items such as clothing. Meaningful engagement for people living with dementia can reduce the risk of them becoming emotionally distressed.

● We shared the above information with the registered manager, regional director and managing director. They accepted that on the day of visit there were limited activities and said that this was in part due to the activity's coordinator leaving but also due to items to be used for activities and engagement being locked away by the activities coordinator who had left. They told us they had resolved this issue and were now recruiting for a dedicated activities coordinator who would base themselves on the dementia unit and provide more specialised and meaningful activities for these people. They also told us they were investing in making improvements to the environment on the dementia unit so this was more stimulating.

● The service was supporting people to have visitors, either in their bedrooms or in a purpose built COVID19 secure pod in a vacant bedroom. However, relatives told us they were not always able to keep in touch with their loved one by other means. For example, they said that staff rarely answered the phone or didn't call back. One relative said the telephone always cut out before the staff member could get it to their relative. Another one told us that they hadn't had much support with video calling to keep in touch. This meant we were not assured that people were consistently supported to keep in contact with people that mattered to them.

Meeting people's communication needs
Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.
● Information was not always communicated to people in a way they could understand, taking into account their individual needs. For example, there were menu's available in the dining room setting out what was on offer that day. However, they were in small text and did not include any photographs which might be helpful for people living with dementia. However, we did observe that people living with dementia were shown both meal options so they could make a visual choice.
● The way in which people communicated and what that may mean was not always set out in enough detail in their care records. We spoke with one person who was blind and saw that their care plans didn't set out any specific instructions for staff on how to support them with this. The person told us that they liked to keep up to date with the news and prior to COVID19 they had received an audio newspaper but that this had stopped in the pandemic. They told us they had to wait for their friend to come and read the paper to them as staff did not. We observed there was a stack of newspapers which the person said they'd have to wait until their friends visit the following week to hear.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control
● Care plans had been developed to include more about peoples likes, dislikes, hobbies and interests since the previous inspection. However, people we spoke with said they had not been involved in discussions about their care planning. One person said, "I know of my care plan, but they did not discuss it with me." Three relatives also told us they were not aware of and had not been involved in their family members care plan. Therefore, it was unclear how accurate and person-centred information could be consistently gathered about people.
● People's interaction with staff was task focussed, and our observations concluded that staff didn't have time to socialise with people. People told us any conversation they had with care staff was when they were receiving support such as with washing and dressing, which confirmed our observations. One person said, "Staff don't have time to sit and talk to us, they are busy". Another person told us, "Not enough time [for staff] to sit and talk, too busy."

This was a breach of Regulation 9: Person Centred Care of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

End of life care and support
● End of life care planning was in place which made clear people's preferences and wishes at the end of their life. This means the service could provide them with more person-centred care.
● The service maintained good links with other healthcare professionals to enable them to support people effectively at the end of their life.

Improving care quality in response to complaints or concerns
● There was a suitable complaints policy in place. However, people and relatives we spoke with were unsure of how to make a complaint and stated this was partly due to the management changes. One relative said, "I would like clarity of rules, I'm not sure who to complain to."
● We reviewed the records held by the service in relation to two complaints and found these were investigated thoroughly and actions were implemented as a result. One complaint was regarding the cleanliness of someone's room and malodour, and we checked on this during our visit and found this bedroom was now clean and free from odour. This assured us action had been taken.

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 'Requires Improvement'. 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 and continuous learning and improving care

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong, managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

● The management of the service had been inconsistent for some time and this meant people and their relatives were unsure about who they could contact if they had a concern. Since 2013 there have been eight registered managers at Oulton Park Care Centre, which means there has been an inconsistent approach to making the necessary improvements that have been identified at four previous inspections.

● Audits carried out by the provider show that areas for improvement were identified and these were placed onto their action plan. However, this did not always lead to timely action. For example, following an audit and discussions with staff and people using the service, it was identified that they made negative comments about the numbers of staff. This was placed on the action plan but improvements to staffing had not been made by the time of our visit.

● The service has a history of non-compliance and has been unable to reach and maintain compliance since 6 November 2018, when it was rated 'Requires Improvement' in the Safe, Responsive and Well-Led domains. It was also in breach of Regulation 12: Safe Care and Treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because there were shortfalls in medicines administration and in how risks to people were monitored and mitigated. At an inspection on 3 April 2019 we found that the service had failed to reach 'Good' and remained rated 'Requires Improvement' in the Safe and Well-Led domains. However, they had made enough improvements to comply with Regulation 12. On 11 December 2019 a further inspection was carried out and the service remained rated 'Requires Improvement' in the Safe, Responsive and Well-Led domains. They had not sustained compliance with Regulation 12: Safe Care and Treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and we found that medicines were yet again not being safely managed and administered. At this inspection we found that improvements had been made with medicines, but the service had deteriorated in other areas. This means we are not assured that there has been appropriate oversight and management of this service to ensure people consistently receive safe care which meets their needs. Whilst the service is responsive to concerns raised by us and other organisations, they have not always been proactive in identifying shortfalls themselves and in taking appropriate action.

This was a breach of regulation 17: Good Governance of the Health and Social Care Act 2008 (Regulated

Activities) Regulations 2014

● Whilst positive comments were made about care staff and the impact they had on people's lives, negative comments were also made about the management of the service and the visibility of the registered manager. One relative said, "The care staff are approachable but not the management, they always seem to pass the buck." Another relative said, "I know who the manager is and everything we talk about seems to be hard work. No one seems to know what the other is doing; they are not consistent." One other relative commented, "I do know that there is a new manager, they change too many times. The carers are the ones that make sure that the place ticks over."

● At the end of our inspection visit we shared our most serious concerns with the registered manager and the managing director, so that prompt action could be taken to mitigate the risks we had identified. Both the registered manager and managing director gave us assurances that action would be taken in response to shortfalls identified and sent us a detailed response to each concern following the inspection, setting out how they would or had already addressed these. They confirmed what oversight would be in place to monitor the progress on improvements going forward.

Working in partnership with others
● The service had formed relationships with other organisations such as Suffolk County Council, the Clinical Commissioning Group and district nursing teams.

● Whilst the service did contact other professionals for advice where this was appropriate, they did not always put this advice into practice.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
● Shortfalls in staffing had not been acted upon in a timely way by the management of the service, which did not promote good outcomes for people who were bored, disengaged and socially isolated.

● Whilst staff were kind, caring and knew people well, they were not supported by the provider to have enough time to care for people in a way which was not task focussed and to spend meaningful time with people, making them feel as if they mattered.

● Despite how busy staff were, when speaking with us about what they would like to change, they all spoke of how improvements to the staffing level could enrich the lives of the people they cared for. This demonstrated they put the needs of those they cared for before their own. This was supported by our observations of staff not taking breaks for lunch until late in the day to make sure there were still staff available to support people.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● People were given opportunities to feedback their views through surveys and meetings. However, relatives told us they felt that nothing happened as a result of feedback they gave. A person using the service said, "I think that communication with the residents can be improved upon".

● Some relatives told us they did not feel involved in the care of their loved one. However, they did say the service usually kept them informed if their relative was unwell or had an accident.

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 Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care 9.— 1.The care and treatment of service users must— a.be appropriate, b.meet their needs, and c.reflect their preferences.