

Sanpas Limited

# Oakwood Nursing Home

## Inspection report

8 The Drive  
Kingsley  
Northampton  
Northamptonshire  
NN1 4SA

Tel: 01604713098

Date of inspection visit:  
28 April 2021

Date of publication:  
05 July 2021

## 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 Nursing Home is a residential care home providing personal and nursing care to 12 people aged 65 and over at the time of the inspection. The service can support up to 29 people.

Accommodation is set out across two floors with private rooms sharing communal bathrooms. There is a communal lounge and dining area and access to a courtyard garden.

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

Risks to people from the environment and health conditions were not consistently well managed. People were not consistently protected from the risk of infection.

The providers systems and processes were not consistently effective in identifying areas of concern.

The provider did not have a registered manager in place at the time of the inspection.

There was a system for reporting accidents and incidents and the provider and manager understood the need to be open and transparent if things went wrong.

People were protected from the risk of abuse.

Staff were recruited safely and there were enough staff to meet peoples' needs.

Medicines were managed safely.

People and their relatives were involved in the care, they were well informed of changes and received regular contact.

Staff received regular support and supervision and felt listened to by the provider and management team.

The staff and management team worked in partnership with other professionals to ensure peoples' needs were met.

The provider and management team were in the process of reviewing the service at the time of the inspection with the aim of improving the safety and quality of the service.

For more details, please see the full report which is on the CQC website at [www.cqc.org.uk](http://www.cqc.org.uk)

### Rating at last inspection

The last rating for this service was requires improvement (published 23 January 2020). The provider

completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection enough improvement had not been made and the provider was still in breach of regulations.

#### Why we inspected

The inspection was prompted in part due to concerns received about the managerial oversight of the service. A decision was made for us to inspect and examine those risks.

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.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Oakwood Nursing Home on our website at [www.cqc.org.uk](http://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 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 the safety, quality and governance of the service at this inspection.

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 for 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 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?**

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 Nursing Home

## Detailed findings

### Background to this inspection

#### The inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

As part of 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 one inspector on site and a second inspector making calls to staff and relatives.

Oakwood 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 does not have a manager registered with the Care Quality Commission. This means that the provider is legally responsible for how the service is run and for the quality and safety of the care provided.

#### Notice of inspection

We gave a short period notice of the inspection prior to entering the building, this was to help the service and us manage any risks associated with COVID-19.

#### What we did before the 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.

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.

We used all of this information to plan our inspection.

During the inspection

We spoke with one person who used the service and five relatives about their experience of the care provided. We spoke with nine members of staff including, the manager, deputy manager, three care workers, one nurse, the activity coordinator and a kitchen assistant.

We reviewed a range of records. This included two people's care records and multiple medication records. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection

We continued to seek clarification from the provider to validate evidence found. We looked at two staff files in relation to recruitment, staff rota's, policy and procedures, maintenance certificates, nurse professional registration evidence and infection control records. We spoke with one professional who visits the service.

# 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 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; Preventing and controlling infection

At our last inspection the provider had failed to ensure people received safe care and treatment. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12.

- Risks to people from the environment were not consistently assessed and mitigated. For example, we identified risks around fire such as a blocked fire escape route. Peoples' personal emergency evacuation plans had not been collated for easy access in the event of an emergency evacuation and the emergency evacuation list was also found to be out of date. This meant people were at increased risk of their escape being delayed in the event of an emergency evacuation.
- Risks to people of falling from height had not been mitigated, window openings were not consistently restricted and restrictors that were in place did not meet the health and safety executive requirement.
- Periodic checks to ensure peoples safety had not consistently taken place during the inspection, we identified two people that had not received their hourly checks as planned.
- Risks to people's health were not consistently well managed. We identified a person with diabetes did not have a detailed care plan or protocol in place to support staff. The persons nutritional support plan did not include guidance on appropriate food options. This meant the person was at potential risk of not being supported safely by staff to manage their health condition.
- Risks around dehydration were not consistently well managed. We identified that fluid intake was not consistently being calculated daily to ensure the risk of dehydration was mitigated.
- We identified one person using an oil filled portable radiator in their room, the radiator was not guarded and there was no risk assessment in place. During the inspection the hourly checks for this person had not consistently taken place as planned. This meant there was an increased potential risk to the person of burns.
- Cleaning schedules were not specific to the home and had not consistently been completed. Cleaning staff did not have clear guidance to ensure all areas of cleaning within the home was completed.
- High touch cleaning was not consistently recorded by staff when the cleaning staff were absent, therefore we could not be assured this consistently took place.
- Kitchen windows which were open at the time of the inspection did not have screening to ensure pests were prevented from contaminating food.

- Laundry practices required improvement to limit the handling of soiled laundry and prevent the risk of transfer of infection.

We found no evidence that people had been harmed however, systems were either not in place or robust enough to demonstrate safety was well managed and risks were mitigated. This placed people at risk of harm. This was a continued breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We highlighted our concerns with the manager who following the inspection provided evidence of action taken to mitigate risk.

- Staff had access to the right equipment to support them with moving people safely. For example, hoisting equipment was in good mechanical condition and was serviced regularly. Staff understood the importance and principles of safe moving and handling and ensured they followed correct staff ratios when supporting people.
- The home was visibly clean and free from malodour.
- The provider ensured an adequate supply of PPE was available for staff and we saw this was being used appropriately. Staff were able to explain the procedures for putting on and taking off (donning and doffing) PPE.
- Staff uniforms were laundered on site to further prevent the transfer of 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 using PPE effectively and safely.
- 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 the provider was facilitating visits for people living in the home in accordance with the current guidance.

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

#### Using medicines safely

- Medicines were administered stored and disposed of safely. Trained nurses were responsible for giving people their medicine. Medicine charts gave clear instruction and were completed appropriately.
- People received their medicines when they needed them and as prescribed. The manager and deputy manager were further developing as and when required (PRN) medicine protocols at the time of the inspection, with part of this work already completed. This work included ensuring staff had detailed information for staff to recognise pain for people who had communication difficulties.

#### Staffing and recruitment

- There were enough staff available to meet people's needs. One staff member told us there had been a recent increase in staff numbers which meant staff had more time to spend with people.
- Staff were recruited safely. There was a recruitment process in place that ensured only suitable staff were employed, this included an interview process, reference checks and an induction program which included training and shadowing experienced staff.
- Disclosure and Barring Service (DBS) checks were completed for all staff prior to them working with people. The DBS carry out a criminal record and barring check on individuals who intend to work with



children and vulnerable adults, to help employers make safer recruitment decisions.

Systems and processes to safeguard people from the risk of abuse

- People were protected from the risk of abuse. Staff had received training and understood how and where to report concerns. Relatives told us they felt their family member was safe in the home. One relative said, "[Persons name] feels safe and well looked after. They (staff) come into [person's name] room to check [person's name] is ok".
- Staff concerns had been recorded and actioned appropriately by the management team in partnership with the people the concerns involved.

Learning lessons when things go wrong

- There had been no incidents, accidents or near miss since our last inspection. However, systems and processes were in place for recording and the manager had a good understanding of their responsibility in this area to ensure thorough investigation, reporting and prevention of reoccurrence.

# 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 remained the same. 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

At our last inspection the provider had failed to ensure adequate systems and processes were in place to assess, monitor and improve the quality and safety of the care provided. This was a breach of regulation 17 (good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17.

- Internal Systems and processes had not identified the areas of concern in the environment that we found during the inspection. For example, environmental audits had not identified the risks around fire and evacuation, and there was no scheduled routine checks to ensure all fire doors were in working order.
- We were not reassured that audits were consistently taking place. We found one audit which had been initially completed then reviewed for 12 consecutive months with some areas marked as compliant which we found were not.
- Policies and procedures had not been updated regularly to ensure they were in line with the latest guidance and best practice. For example, the selection and recruitment of staff policy contained outdated information on criminal records checks. However, we were reassured the correct checks were taking place.

We found no evidence that people had been harmed however, systems were either not in place or robust enough to demonstrate risk was consistently managed safely. This placed people at risk of harm. This was a continued breach of regulation 17 (good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- There was no registered manager in post at the time of the inspection. The provider had commissioned an experienced part time consultant manager who had been with the service for a short period of time at the time of the inspection. The manager had a plan to review all areas of the service and the first action plan was in place. The improvements would need to be continued and embedded in practice to ensure the safety and managerial oversight of the service improved.

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

- Care plans required improvement to ensure they were written in a more person-centred way and include more detail. However, we found that staff knew people well and were respectful of their choices and preferences. One relative told us that staff knew what their family member liked, and staff played music from a religious organisation that the person belonged to, which they enjoyed.
- Staff told us they had time to spend with people to ensure they were well cared for. One staff member said, "I tell [person's name] they are beautiful, we dance and have a joke. They [people] are like my family. I enjoy it very much."

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

- People were encouraged and supported to share their opinions via regular meetings and surveys, people with communication difficulties had been given 1 to 1 support to express their opinion and families were also included.
- Families told us they felt included in their relative's care, communication from the home was good, they could phone anytime and staff were helpful and informative. One relative said, "They (staff) keep in contact, they've sent some photos through (of family member)."
- Staff felt part of a team and described morale as good. Staff told us they felt listened to by the management team and received regular supervision and support.

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 and manager had a good understanding of the duty of candour and the legal requirement to be open and honest with people and their families.

Continuous learning and improving care; Working in partnership with others

- The provider had not addressed all areas from the previous inspection breaches. However, they were taking guidance from the manager and demonstrated financial commitment to improvements in the safety and quality of the service. This would need to be continued and embedded in practice.
- The manager was in the process of reviewing electronic care planning systems to implement in the service. This was to ensure the provider could maintain more effective oversight of the safety and quality of the service.
- There was evidence of partnership working with other professionals to ensure people's care and support needs were met, such as audiologists, GP's and chiropodists.