Northfields Care Homes Limited

Oxford Grange Care Home

Inspection report

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Date of inspection visit: 22/05/2015
Date of publication: 20/07/2015

Overall summary

We carried out an unannounced comprehensive inspection of this service on 8, 10 and 12 May 2015. We identified breaches of 10 regulations and said that the service must make immediate improvement. This inspection resulted in an overall rating for the service of 'Inadequate'.

We received information of concern from the interim manager following the above inspection visits to Oxford Grange. This related to people who lived at the home being put at risk because they were not receiving safe or adequate care and the interim manager told us there had been no improvements to the standard of care. We were told there were conflicts in the temporary leadership of the home.

We undertook a focused inspection on 22 May 2015 to look into these concerns

This report only covers our findings in relation to these areas. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Oxford Grange on our website at www.cqc.org.uk'

This inspection did not change any of the ratings made as a result of our comprehensive inspection on 8, 10 and 12 May 2015.

Oxford Grange provides residential care for up to 43 older people. Nursing care is not provided. At the time of our visit there were 34 people living at the home. There was no registered manager at the home. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

When we conduct comprehensive inspections, we report our findings under the five domains: Safe, Effective, Caring, Responsive and Well Led. All our findings from this inspection come within the Safe, Effective and Well Led domains.

We found that although the provider had brought in additional staff from an agency, staff lacked knowledge of people's needs to safely manage their care.

We saw moving and handling practises that were unsafe and people were at risk of injury.

We saw people with injuries that staff could not clearly explain and which were not documented.

People living in the home were unhappy and distressed and their rights were not being promoted.

People who lived the home were not adequately supported to eat and drink and there was insufficient evidence available to show that all of the people living at the home were receiving a diet suitable to their needs and preferences.

Communication between staff was poor so that essential information about people was not shared in order for their care needs to be met.

Summary of findings

Records about people's care were inadequate; either not in place or incorrectly filled in.

We found that the registered provider had failed to maintain effective leadership within the home and staff lacked direction.

The overall rating for this provider is 'Inadequate'. This means that it has been placed into 'Special measures' by CQC. The purpose of special measures is to:

Ensure that providers found to be providing inadequate care significantly improve

Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.

Provide a clear timeframe within which providers must improve the quality of care they provide or we will seek to take further action, for example cancel their registration.

In this inspection we found insufficient improvements and we had further serious concerns. This caused us to take urgent action in line with our enforcement procedures to prevent the provider from operating the service. We have moved to close the service by adopting our proposal to vary the provider's registration to remove this location.

Summary of findings

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 safe.

People were not safe from injury because staff did not follow safe moving and handling procedures or provide suitable pressure relief when required.

People had injuries that staff could not account for and that were not recorded.

Is the service effective?
The service was not effective.

Staff lacked knowledge of people's needs and skills to manage people's health care.

People were not provided with sufficient food and drinks and those who required assistance with meals were not effectively supported.

Is the service caring?
We did not report under this heading as part of this focused inspection.

Is the service responsive?
We did not report under this heading as part of this focused inspection.

Is the service well-led?
The service was not well led.

Staff who said they were in charge did not know how many people lived in the home, the names of the staff they were working with, or critical matters relating to people's care.

Staff handover meeting between shifts were highly ineffective.

Staff lacked direction and there were no clear lines of responsibility or accountability.

Oxford Grange Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008.

A comprehensive inspection had been carried out on 8, 10 and 12 May 2015 which had highlighted very serious concerns. Prior to this inspection the Care Quality Commission had received further significant and serious concerns about the care and welfare of the people living at the home.

This inspection took place on 22 May 2015 and was unannounced. The inspection was carried out by 3 adult social care inspectors.

During visits we spoke with 12 people who lived at the home, and 4 members of staff including the manager. We also spoke with six members of agency staff working at the home. We looked around the home, observed practice and looked at records. This included 4 people's care records and records relating to the management of the service

Is the service safe?

Our findings

We saw one person had a dressing on their arm; staff we spoke with did not know how the injury had happened. We saw this had not been recorded. Another person had bruising to their face and staff were not able to clearly tell us what had happened. Again, there was no accident record to show how this had happened or what action had been taken.

One person we spoke with said they liked to be clean shaven, but told us staff were rough when carrying out this aspect of their personal care and this sometimes made their face sore.

We saw one person with an open sore to their nose and grazing to their forehead. When we asked this person what had happened they said "It's these here that do it, they bruised my arms as well, they are nasty (expletive). We asked this person who they meant, they said it was "These young women who are supposed to help me" This person went on to say "These young women here give you hell when they shower you. One day I was shouting but they just ignore you, I weed all in my trousers, I was choked up". We ensured that this matter was referred to the local safeguarding team.

Prior to this visit the interim manager had reported to us they had heard a member of staff shout at a person, but they told us they had not challenged this.

This meant the provider had failed to maintain the safety of people living at the home. This is a continued breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw that since our previous inspection staff numbers had been increased and agency staff had been employed. Although we observed there were many staff on duty, staff lacked skill and competency in meeting people's needs. Staff we spoke with did not understand people's needs or their individual risks. Agency staff told us this was their first time in the home and they did not know anything about the people they were supporting. We saw one person who we knew from our previous inspection needed to sit on a pressure relieving cushion, was seated on a hard dining chair. We asked the member of agency staff who sat with this person to tell us what they knew about them. They replied: "I'm sorry, I don't know anything about them at all".

We asked a member of staff who was seated beside a person in a wheelchair how the person needed to be assisted to move. The member of staff said: "I don't really know. I'd have to ask someone".

We saw staff assisted people in an unsafe manner. For example, staff moved one person in their wheelchair, but the person's foot was trailing on the floor so the member of staff crossed the person's leg over the other leg and continued to move them. On another occasion, two staff assisted a person from their armchair to their wheelchair. We saw the person was unsteady on their feet and made a staggering movement. This caused staff to clutch the person's clothing and they sat clumsily in the wheelchair.

We saw one person wearing slippers that were clearly too big for them and this caused them to shuffle and stumble. We asked a member of staff if they were aware this was a trip hazard to the person; the member of staff shook their head. We asked staff to make sure the person had suitable footwear to prevent them from falling.

This meant the provider had failed to ensure the safe care and treatment of people living at the home. This is a continued breach of regulation 12(1) and (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw agency nurses had been employed to administer medicines to people. The interim manager told us medication rounds were taking too much time and people were not getting their medicines when they should have done. We saw the agency nurse was accompanied by a regular member of staff so that people could be identified. However, the agency nurse said that this caused the task of giving medication to be very slow.

Is the service effective?

Our findings

Our inspection of 8, 10 and 12 May 2015 gave us cause for concern that people who lived at the home were being put at risk because they were not receiving adequate nutrition. At this inspection we checked to see whether people were having appropriate food and drink for their needs and preferences. We found people's dietary needs were still not met.

One person told us mid-morning: "I'll feel better when I've eaten something". We found this person had not been provided with anything to eat or drink since the previous evening. Another person said: "I'm so thirsty, I'll have anything". We saw people had to wait a long time for their breakfast and whilst some people were given food, others were not given anything. When we asked staff, they did not know who had eaten and who had not. For example we saw one member of staff assisted a person with their breakfast and 15 minutes later another member of staff attempted to offer breakfast to the same person. On one occasion we heard two members of staff disagreed openly about whether a person had eaten breakfast. One staff member said the person needed something to eat; another member of staff said: "I think they have already eaten".

We saw a member of agency staff attempted to put a spoonful of cereal to a person's mouth whilst they were sleeping. The member of staff referred to the person by the wrong name as they tried to wake them by putting the spoon to their mouth. We spoke with the member of staff and asked what time the person had woken up, whether they had already eaten and what the person's needs, preferences and abilities were. The member of staff told us they did not know. We knew from our previous inspection this person did not require full assistance with their meal and were capable of feeding themselves. The member of staff continued to try to feed the person until we intervened and pointed out this was inappropriate. We later saw this person's dentures were still in their room and they had been brought to the dining table without them.

Staff told us they had been asked to complete new documentation following our previous inspection, to record people's food and fluid intake. Staff said they had to complete these records for all the people living in the home. We looked at these records and found only eight records had been completed out of 34 for the day of our inspection. For the records that were completed we saw there was false information documented. For example, one person's record showed they had eaten a cooked breakfast, yet we saw they were only given cereal. We asked staff about when they completed the records and they told us they tried to do this but did not always remember what people had eaten and so records could not always be filled in.

When we inspected this service on 8, 10 and 12 May we identified a breach of regulation 14(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and said that immediate improvements were needed in relation to meeting people's nutritional needs. We did not find sufficient evidence to demonstrate that the required improvements had been made. This therefore demonstrates a continued breach of regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The interim manager told us staff were not competent to assess when a person's health required emergency intervention. She told us about a situation in which a person had to be taken to hospital but staff had been slow notice signs of ill health and refer this on appropriately. Staff we spoke with could not tell us what additional care the person needed following their return to the home. We were concerned that staff told us one person was receiving end of their life care, yet their records did not show how this had been determined or what medical interventions and advice had been obtained. Staff were unable to account for the deterioration in the person's health or to show how their care was being managed.

We saw one person who we had noted at our last inspection to have a particular health condition and saw this was still making them very uncomfortable at this visit. We spoke with staff who were unaware of the person's needs or treatment for this condition.

We saw that one person had been treated in hospital the day before our inspection for an acute health condition. The person was still unwell and asked staff several times for a drink of orange juice as they were very thirsty. Staff ignored this person and we had to intervene and ask staff to provide this person with a drink of orange juice. A member of agency staff brought a mug of milk which the person said they didn't want. Again we intervened and

Is the service effective?

asked for orange juice. We asked a member of staff if the person had had a good fluid intake since their return from hospital. The member of staff said they didn't know the person had been to hospital.

We witnessed people who we knew from our last inspection needed to use pressure relieving cushions, yet were still not provided with them.

We saw one person who was very ill and needed pressure care area but staff we spoke with were not clear how often this person needed to be assisted. The agency nurse said this person needed to be repositioned every two hours, yet care staff we spoke with were unaware of this and there were incomplete records of this in place.

Is the service caring?

Our findings

We did not report under this heading as part of this focused inspection.

Is the service responsive?

Our findings

We did not report under this heading as part of this focused inspection.

Is the service well-led?

Our findings

We arrived early in the morning and spoke with the team leader who had worked the night shift. The team leader did not know the names of the staff who had been on duty and had no knowledge of how many people were living in the home.

We observed the handover from night staff to day staff and saw this was done three times; once between the two team leaders, once from the team leader to the regular staff and again from the team leader to the agency staff. However, we saw the information given was scant and lacked important detail for staff to be able to provide safe care. Furthermore, each time the information was given, some details changed. For example, one person's moving and handling needs were described differently at each handover. Staff receiving handover information made no notes about what was being said. We spoke with agency staff after the handover and they confirmed they did not know which people were being spoken about and said the handover had little meaning to them. The agency nurse was not fully informed about when the handover would take place and had to seek information from the team leader. Staff who came on duty after the handover had taken place did not receive any information about people.

At this inspection we spoke with the interim manager who told us she had received no handover information upon arrival on duty and lacked knowledge of key information, such as two people who were significantly unwell. The interim manager said there was no clear line of accountability for the running of the home. We were told information was not being shared effectively with those responsible for ensuring the home was run and managed safely. The interim manager told us the home was not running properly and people were receiving unsafe care.

This demonstrates a failure on the part of the provider to provide effective leadership and governance of the service as the quality of the service was not appropriately managed and risks in the service had not been properly identified and dealt with. This a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **The provider had failed to ensure the safe care and treatment of people living at the home.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment **The provider had failed to maintain the safety of people living at the home.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA (RA) Regulations 2014 Meeting nutritional and hydration needs **The provider had failed to ensure people's nutritional and hydration needs were met.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance **The provider had failed to assess, monitor and mitigate the risks relating to the health, safety and welfare of people who use the service.**