Elmcare Limited

Oakwood Bungalows

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

We expect health and social care providers to guarantee people with a learning disability and autistic people respect, equality, dignity, choices and independence and good access to local communities that most people take for granted. 'Right support, right care, right culture' is the guidance CQC follows to make assessments and judgements about services supporting people with a learning disability and autistic people and providers must have regard to it.

About the service
Oakwood Bungalows is a residential care home providing personal and nursing care to 11 people at the time of the inspection. The service can support up to a maximum of 11 people. The service supports people with a learning disability and autistic people, and younger adults. People lived in 2 bungalows, one with 10 beds and another single occupancy bungalow.

People's experience of using this service and what we found
Right Support:
Fire safety risks were not always assessed or mitigated, placing people at risk of harm.

A system to analyse accidents and incidents had not been implemented. This meant action to prevent further risk of incidents or accidents was not always identified. Governance arrangements were not effective to fully ensure the quality and safety of people's care.

Staff used techniques to support people to manage their emotions, this approach reduced the need for people to be supported through the use of restraint. Staff recorded where restraint was required to keep people and others safe. However, some improvements were required to ensure lessons were learned from those incidents to reduce them happening again.

People were not supported in an environment offering interaction and stimulation at a level of intensity to meet their needs. The service was clean and well maintained.

Staff supported people with their medicines in a way that promoted their independence and achieved the best possible health outcome. Referrals to appropriate professionals were made in a timely manner.

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 policies and systems in the service supported this practice.

Right Care:
Safeguarding referrals or investigations had not always been made where records showed people were at risk of poor care and abuse. Where safeguarding referrals had been made, the service worked in partnership with social care organisations to protect people.

Staff had not always received up to date training but following inspection were encouraged to complete this within a set timeframe. The service had enough staff to meet people's needs and keep them safe.

Staff and people cooperated to assess risks people might face. Where appropriate, staff encouraged and enabled people to take positive risks.

Right Culture:
Staff had enough guidance to support people to manage their distress, anxiety, feelings and emotional reactions in a personalised way.

The provider made reasonable adjustments for people so they could be involved in discussions about their support and the service. There were opportunities for staff to feedback on the running of the service.

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

Rating at last inspection
The last rating for this service was good (published 4 March 2020).

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

We have found evidence that the provider needs to make improvements. Please see the safe and well-led sections of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Oakwood Bungalows on our website at www.cqc.org.uk.

Enforcement and Recommendations
We have identified breaches in relation to safeguarding, safety and governance 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.
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 from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below.

Oakwood Bungalows

Detailed findings

Background to this inspection

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

As part of this inspection we looked at the infection control and prevention measures in place. 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 2 inspectors, a specialist nurse advisor 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
Oakwood Bungalows is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Oakwood Bungalows is a care home with nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was not a registered manager in post. A new manager had been in post for one month and had submitted an application to register. We are currently assessing this application.

Notice of inspection
This inspection was unannounced.

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. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We spoke with 4 people who use the service and 6 relatives of people who use the service. We requested feedback from 2 professionals who work with the service. We spoke with 8 staff, including the manager, regional manager, clinical lead, team leaders, support workers and kitchen staff. We spent time observing staff interactions with people.

We reviewed a range of records, including 5 people's care records and a number of medicine administration records. We looked at 2 staff recruitment files. A variety of records relating to the management of the service, including quality assurance records, and some of the provider's operational policies were also reviewed.

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Systems and processes to safeguard people from the risk of abuse

- The provider did not always refer to safeguarding when concerns about abuse were raised. For example, we found body maps completed for people who had unexplained bruising. There had been no review, or investigation of these body maps by the provider. There were no records to evidence these events had been escalated to the local authority safeguarding team for investigation.
- Staff used language which indicated potential punitive measures when supporting people who displayed signs of distress. Some accident and incident forms stated people had been 'sent' to their bedroom, or 'moved' to the office to 'calm down'. These forms had not been reviewed by the manager, which meant people could have been at risk of abuse.

Concerns about abuse were not always identified or referred to the local authority safeguarding team. This was a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The manager responded immediately and told us they felt confident that punitive measures were not used within the service, but it was more so an issue around the use of language within the accident and incident forms and they would address this with staff.

Assessing risk, safety monitoring and management

- People were not fully protected from the risk of fire. There was no risk assessment in place for the use of emollient creams within the service. Emollient creams can transfer onto fabric making them more flammable. As there were people who smoked at the service, this increased the risk.
- There were no recorded fire drills since April 2021. Some staff had started working at the service after this date. Not all staff had completed fire safety assessment training. This increased the risk in the event of an emergency evacuation.

People were not fully protected from the risk of fire. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The manager responded immediately and told us they had given staff a timescale to complete all mandatory training.

- People told us they felt safe using the service. People had members of staff they felt able to talk to in the event they did not feel safe. One relative told us, "Staff tell me anything they're concerned about."
- The provider worked alongside the local authority to investigate safeguarding referrals that had been

made.

● People's risks were identified and assessed. Risk assessments contained clear and up to date guidance on how to support people safely. For example, one person had a health condition which required close monitoring, their support plan detailed signs and symptoms for staff to be aware of and when the person required medical intervention. People were supported to take positive risks.
● Each person's care and support plan included ways to avoid or minimise the need for restricting their freedom. Staff could recognise signs when people experienced emotional distress and knew how to support them safely.
● Staff made every attempt to avoid restraining people and did so only when de-escalation techniques had failed and when necessary to keep the person or others safe.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The MCA requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the Mental Capacity Act (MCA). In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS)

● We found the service was working within the principles of the MCA and if needed, appropriate legal authorisations were in place to deprive a person of their liberty. Any conditions related to DoLS authorisations were being met.

Learning lessons when things go wrong
● Staff recorded all accidents and incidents; however further improvements were needed to ensure lessons were learned when things went wrong. Debriefs were not consistently carried out following accidents or incidents. During our inspection the manager implemented a debrief folder to ensure learning from significant accidents and incidents.
● Staff managed incidents affecting people's safety in line with written guidance within their care plans. During our inspection we observed staff to support a person who was displaying signs of distress appropriately and safely.

Staffing and recruitment
● Not all staff had received up to date training. Following our inspection, the manager confirmed all staff were reminded to complete any outstanding training and given a deadline for completion.
● Not all staff had up to date information within their recruitment files. One person's Disclosure and Barring Service (DBS) check had expired. DBS checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions. The manager immediately implemented a risk assessment to mitigate any risks whilst awaiting their updated DBS.
● There were enough staff to meet the needs of people safely. This included ensuring staff were available to provide peoples commissioned one to one support. Staff were not rushed, and people did not have to wait for support.
● People's care records contained a clear pen picture with essential information and dos and don'ts to ensure that new or temporary staff could see quickly how best to support them.

Using medicines safely

● Overall, medicines were stored, administered and managed safely. Some medicine was overstocked, for example one person had around 57 insulin pens due to a lack of effective rotation system in place. However, no medicine was found to be out of date or unsafe to use.

● People received their medicines as prescribed. The service ensured people's behaviour was not controlled by excessive and inappropriate use of medicines. Staff understood and implemented the principles of STOMP (stopping over-medication of people with a learning disability, autism or both) and ensured that people's medicines were reviewed by prescribers in line with these principles.

● Staff administered medicines safely. People received support from staff to make their own decisions about medicines wherever possible. We observed staff administer medicines in a kind, patient and person-centred manner.

● The provider worked with relevant healthcare professionals, such as the local pharmacy and GP to ensure people's medicines were reviewed regularly.

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 supporting people living at the service to minimise the spread of infection.

● 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 responding effectively to risks and signs of infection.

● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.

● 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.

Visiting in care homes

Visiting took place in line with current government guidance. There were no restrictions upon visitors to the home.

Requires Improvement

Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

- Systems and processes to ensure oversight of risk had not always been implemented. No quality assurance audits had been completed in October 2022 or November 2022. This meant there was no effective management oversight of risk during this time. This placed people at risk of harm.
- Quality assurance systems were not always effective in identifying areas for improvement. For example, clinical audits had not identified the overstocking of insulin within the service.
- Action plans were not always used to drive improvement. Where issues were identified, action plans did not always clearly identify who was responsible for carrying out the action, what specific action was required and whether this had been completed within the specified timescale. For example, one action plan had identified '1 person's risk assessment needs updating', it did not identify who this person was, or which risk assessment required attention.
- Effective action had not always been taken following quality audits to mitigate risk or drive improvement. For example, an audit had identified fridge temperatures were not always recorded. During our inspection, fridge temperatures had not been recorded for 6 dates in January 2023.
- Accidents and incidents that affected the safety and welfare of people were not always investigated. This meant action to prevent further risk of incidents or accidents was not always identified. One person using the service had over 26 incidents recorded in one month, however no analysis of these had taken place to identify themes or trends to help keep the person safe.
- Records relating to the employment of people carrying out regulated activity were not always kept securely. The provider was unable to locate a recruitment file for one member of staff. This meant it was uncertain whether they had been recruited safely.

Systems had not been established to assess, monitor and mitigate risks to the health, safety and welfare of people using the service. This placed people at risk of harm. This was a breach of regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded immediately during and after the inspection. The manager had commenced consistent audits since being in post and told us they planned to embed a new accident and incident analysis system.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Working in partnership with others

● A positive culture was not always promoted within the home. Staff did not always engage with people in a meaningful way. During our inspection, people were observed to spend time sat in a lounge whilst staff stood and watched them, staff did not always interact with people.
● The service had been without a registered manager for approximately 12 months. Staff reflected on the challenges of being without a consistent manager for this long but felt positive about the current management. One staff told us, "It's getting better, we've been months without stable management but [manager] has come in and made improvements to things." Some relatives felt communication with management could be improved.
● People shared they liked living at Oakwood Bungalows. One relative told us, "[Person] is very happy and they look after her well."
● People were supported to achieve good outcomes. One person using the service told us about their plans to move on to a supported living service. The manager and staff liaised with the relevant professionals to co-ordinate this transition safely.
● The provider worked in partnership with a range of external stakeholders and professionals. The provider also worked with advocacy organisations which helped to give people using the service a voice.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● People and staff had opportunities to be involved in the running of the service. People were encouraged to share their ideas on what they would like the service to do at regular resident meetings. Minutes of meetings were provided in an easy read format for people so they could keep up to date on what was discussed.
● Staff felt supported in their roles. The manager operated an open-door policy which was observed to be utilised during the inspection. One staff told us, "I think [manager] is approachable." Another staff told us, "Yes [manager]'s door is always open, I can go in and talk about anything I need to anytime."
● Regular staff meetings were scheduled which staff told us they found useful. One staff said, "The manager will call us in if we have missed a meeting to let us know of any changes, you can always read the latest minutes on the noticeboard too."

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong
● People received honest information and suitable support. The manager applied duty of candour where appropriate.
● The manager was open and transparent throughout the inspection process and took feedback on board.

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	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Fire safety risks were not always identified or mitigated. This placed people at risk of harm.

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 Safeguarding concerns were not always identified or referred to the local authority. This placed people at risk of potential abuse.

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	Regulation 17 HSCA RA Regulations 2014 Good governance Systems and processes to ensure oversight of risk were not effective. Accidents and incidents that affected the safety and welfare of people were not always investigated. Records relating to those employed to carry out regulated activity were not always kept securely. This placed people at risk of harm

The enforcement action we took:

Warning notice