Caring Homes Healthcare Group Limited

Oak Manor Nursing Home

Inspection report

Oak Manor
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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Oak Manor Nursing Home is a residential care home which provides nursing and personal care for people, some of whom are living with dementia. The service can support up to 61 people and specialises in providing care for people living with dementia. The premises are in a rural setting with all facilities on the ground floor.

People's experience of using this service and what we found
People did not always receive care and support which was safe and met their needs. Safe systems were not in place to reduce the risk and spread of infection, including COVID-19. Staff were not wearing PPE in accordance with government guidance and cleaning procedures were not robust. Oversight of cleaning was poor, and some areas were visibly dirty. This placed people at increased risk.

Some areas of the service were not in a good state of repair. The provider had not made enough adaptation to the service, such as additional handrails, to ensure it was safe for people to move around. The garden remained overgrown and unsafe for people to use. These issues had been identified at previous inspections in May and September 2019.

Although management of incidents between people who used the service had improved, one incident which met the safeguarding threshold and two falls causing injury and hospital admission had not been notified to the Care Quality Commission.

Relatives gave us mostly positive feedback but several commented on poor communication and remained unaware of recent management changes at the service. This poor communication raised relatives' anxieties at a time they were unable to see their relatives due to COVID-19 restrictions on visiting.

The newly appointed manager had made a lot of changes and begun the process of driving improvement. They were held in high regard by the staff. However, many of the significant failures we found had not been identified by them or the provider's audit processes. Audit systems did not always identify concerns or act quickly when things needed to be addressed. This placed people at continued risk of unsafe care and treatment.

The new manager had begun improving the service and the provider's regional manager was supportive of them. However, the failings we indentified led us to have significant concerns about the service. We were pleased to note people's feedback was mostly positive and some aspects of the service were working well. This was particularly clear in relation to increased and more consistent staffing as well as a commitment to more person centred care plans. We were assured by the prompt actions taken to address our urgent concerns about infection prevention and control. However, the fact that some longstanding concerns remained and the poor infection prevention and control we identified during our inspection visit meant we were not assured of the safety and quality of the service.

Rating at last inspection (and update)
The last rating for this service was Requires Improvement (published 11 November 2019) and there were breaches of regulation relating to person centred care and to the premises and equipment. The provider completed an action plan after the last inspection to demonstrate what they planned to do to address the issues we found. At this inspection we found the provider had made improvements relating to person centred care but had not done enough to address the environmental concerns. This meant they remained in breach of the regulation relating to premises. We also identified new breaches of other regulations.

Why we inspected
We received information in relation to poor staffing levels, poor cleanliness, concerns about people's dignity being upheld and poor record keeping. Some of these concerns had been raised by staff. We also had concerns about the ongoing management and oversight of the service. As a result, we undertook a focused inspection to review the key questions of Safe and Well-Led only.

We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.

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 coronavirus and other infection outbreaks effectively.

The overall rating for the service has changed from Good to Inadequate. This is based on the findings at this inspection. We have found evidence that the provider needs to make improvement. Please see the Safe and Well-Led sections of this full report. 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 Oak Manor Nursing Home on our website at www.cqc.org.uk.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to 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 failing to notify CQC as required, poor infection control practice, poor maintenance of the premises and poor leadership and oversight 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.

Special Measures

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.

Is the service well-led?

Inadequate

The service was not well-led.

Oak Manor Nursing Home

Detailed findings

Background to this inspection

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

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
The inspection was carried out by three inspectors, one assistant inspector 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
Oak Manor Nursing Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Notice of inspection
This inspection was unannounced, and the inspection visit began at 07.00 in order to observe early morning staffing, as some concerns had been raised about this. Inspection activity was carried out between 8 October 2019 and 22 October 2019.

What we did before the inspection
We reviewed the information we had received about the service since the last inspection, including notifications the service is required to send us by law. We also reviewed the most recent local authority Provider Assessment and Market Management Solutions (PAMMS) audit which was carried out by their quality monitoring team. We spoke with two staff from the local Clinical Commissioning Group to gain

feedback about people they have placed at the service in order to receive nursing care.

We used all of this information to plan our inspection.

During the inspection
Due to the COVID-19 pandemic the time spent onsite by inspectors was reduced. This was done to help manage any associated risks. Some inspection activity, such as reviewing of records and speaking to some staff and relatives took place remotely.

During the inspection we spoke with one person who used the service and observed staff providing care and support to others. We spoke with twelve relatives, one nurse, one senior care staff member, four care staff, the person in charge of maintenance, one laundry staff member, the head chef and the head of housekeeping. We also spoke with the manager, the regional manager and the operational director.

We reviewed five care records, two medication administration records (MAR) and two staff records. We also reviewed other records, including policies and procedures, relating to the safety and quality of the service.

After the inspection
We continued to seek clarification from the provider after the inspection visit to validate evidence found. We looked at training data, rotas and quality assurance records. Our Expert by Experience carried out calls to relatives and we spoke with care staff to gain their feedback.

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 Good. At this inspection this key question has now deteriorated to Inadequate. This meant people were not safe and were at risk of avoidable harm.

Preventing and controlling infection

● Procedures in place to ensure people were protected from the risk of COVID-19 and other infections were not robust. Staff were not adhering to government guidance regarding the use of personal protective equipment (PPE). We saw staff providing care and support with no masks on, or with masks worn incorrectly, such as hanging from one ear not covering the nose or mouth. Protocols for staff governing how they should put on and take off their PPE safely were not followed. During break times we observed staff failing to maintain safe social distancing. This poor practice placed people at risk.

● There was no signage on the entrance used outside of office hours, which outlined the measures the service had in place to keep people safe. One person, recently discharged from hospital and being nursed in their room to reduce the risk and spread of any acquired infection, had no notice on their door to alert staff and visitors.

●Cleaning schedules were either not in place or were not being followed or robustly monitored. One person's bedroom was found to be dirty with used continence pads being stored in drawers on top of photographs, which had been ruined. The person's care plan indicated that they sometimes hid their pads in drawers but staff had not noticed the ones we found. The room had a very significant odour and had several flies in there. Records showed that the room had been deep cleaned two days previously and routinely cleaned on the previous day. We found dead flies and dust under the bed and an ensuite bathroom in a poor state of repair with bare wood and mould which increased the risk of the spread of infection. We were not assured that the recorded cleaning had taken place or, if it had, it was not thorough.

●Cleaning staff told us that additional cleaning measures had been put in place in response to the risks presented by COVID-19. However, we found that cleaning staff only worked until 15.30 each day. The dining room chairs and tables were not being regularly cleaned. We found breakfast tables were set with tablecloths still dirty from the previous day.

● Touch points, such as light switches and door handles, were supposed to be cleaned every two hours but records did not demonstrate this. After 15.30 care staff were supposed to take over this additional cleaning but the head housekeeper confirmed to us that this was not taking place. Since our inspection the provider has introduced additional monitoring of cleaning and cleaning shifts have been extended to 19.30.

●The provider had cascaded current government guidance regarding infection prevention and control to staff. However, the service's infection control champion showed us out of date guidance which they were following.

This was a breach of Regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. People who used the service were placed at risk because robust procedures to reduce the risk and spread of infection were not in place.

●Staff had received recent infection control training and stocks of personal protective equipment (PPE) were well managed. Staff and people who used the service had been divided into cohorts to try to minimise the risks from cross-infection.

Assessing risk, safety monitoring and management; learning lessons when things go wrong

At our last inspection in September 2019 the provider had failed to ensure that the premises were well maintained. This was a continued breach of Regulation 15 (Premises and Equipment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, as this regulation had also been breached at the previous inspection in May 2019. At this inspection we found the provider had not made the required improvements and remains in breach of this regulation.

●One person's ensuite bathroom was in a very poor state of disrepair with badly worn flooring, bare wooden panels and mould. Other areas of the service were in need of refurbishment.
● At our last inspection we identified that some additional handrails were needed on two steeply sloping areas. These had been put in place but elsewhere there were no handrails to guide people safely. The provider's audit of falls for one person, carried out 4 September 2020, had identified that most falls in June, July and August had been in corridors. The manager had noted an action point about fitting handrails in corridors. No action had been taken to address this by the time of our inspection visit.
●We identified risks associated with the overgrown garden which made it unsafe and unsuitable for people to use. This had been an action point on the provider's action plan following the previous two inspections. We also noted from records that a known trip hazard had not been promptly addressed and the risks of cross infection from shared slings, which had been identified at a previous inspection, had only just been addressed in October 2020 despite there being a global pandemic.

This was a continued breach of Regulation 15 (Premises and Equipment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. People who used the service remained at risk because the provider had not ensured the environment was safe and suitable for them.

●Other risks were not always well managed. We found creams and toiletries were not kept securely and placed people, especially those living with dementia, at potential risk of harm should they try to eat or drink them. We noted a fire exit which was partially blocked by a sofa cushion and would have impeded people's exit from the building. We also noted a fire door being propped open with a chest of drawers which meant it would not be able to close automatically in the event of the fire alarm sounding.
●Individual risk assessments relating to fire evacuation, seizures and to COVID-19 were not completed in all cases. We saw that in one case a person's moving and handling risk assessment had not been updated following a fall and injury which impacted on their mobility. Another person's repositioning chart which had been put in place to help prevent pressure ulcers had gaps in recording. This meant we could not be fully assured that all actions were being taken to reduce this particular risk.

This was a further breach of Regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. People who used the service were placed at risk because risks to their health and safety were not sufficiently monitored and action taken to reduce them.

●Equipment and systems were appropriately maintained and serviced to ensure people were safe.

Using medicines safely
●Medicines, including controlled drugs, were managed safely and people received their medicines as

prescribed. There were effective systems in place to ensure stocks of medicines were available and stock control was well monitored. Staff received training to administer medicines and their competency to do this was assessed.

Staffing and recruitment

●Before our inspection was carried out we had received whistleblowing concerns and complaints about a variety of issues including staffing. During our investigation of these concerns we reviewed staffing levels and we found that some night shifts had operated with a high percentage of agency care staff in June 2020. This reliance on agency staff led us to question whether there was a relationship between the concerns being raised with us and the number of skilled and experienced staff on duty.

●In the last two months the provider had undertaken a robust recruitment drive and the service was now close to having a full complement of permanent staff. They also now had a new manager in post. The service's recruitment procedures were appropriate and aimed to ensure staff were suitable and safe to work in this setting.

●Relatives gave us mostly positive feedback about the staffing both before and during the pandemic. A typical comment we received was, "I think [my relative] is safe because there is always someone there to look after [them] and support [them] to walk." Another said, "I think there is enough staff who are skilled, apart from a blip last March."

Systems and processes to safeguard people from the risk of abuse

●Since our last inspection we found some improvements in the management of people's distressed reactions. The provider had reflected on the high level on incidents between people and had provided additional training for staff and promoted dementia friendly ways of working. The people who used the service and staff had also been grouped into four cohorts. These measures had resulted in a reduction in incidents between people. The provider had begun carrying out further work in this area to analyse people's behaviours to help look for patterns and trends. This work was ongoing.

●Staff received training in safeguarding people from abuse or the risk of abuse and had raised safeguarding alerts with the local authority where they thought a person had been abused or was at risk of abuse. However, CQC had not always been notified about safeguarding concerns and investigations.

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.

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

- There was no registered manager in post but the new manager, who had moved from another of the provider's services, had begun the process of applying to register with CQC. They were an experienced manager and demonstrated an understanding of regulatory requirements.
- Some significant incidents had not been notified to CQC as is required. We identified a number of incidents where people sustained injury or incidents which had been referred to the local authority safeguarding team, which should also have been notified to CQC.

This is a breach of regulation 18 (Notification of other incidents) of the Care Quality Commission (Registration) Regulations 2009.

- At our two previous inspections we found that the garden was not suitable for people living with dementia to use safely. This has still not been addressed and we found the garden was overgrown and not suitable or safe for people to use. We also identified at the September 2019 inspection that each person needed their own sling for purposes of reducing the risk of cross-infection. These new slings had only been purchased in October 2020 which meant that this additional risk remained during times of a global pandemic.
- The daily heads of department meeting on 12 September documented that there was a dip in the concrete in a corridor which was a trip hazard. This risk had still not been addressed on 29 September when we reviewed the minutes from that morning's meeting.
- Care plans were detailed and there was a process of care plan audits in place. However, we found that some key information was still missing and there was some confusion. For example, one relative was upset that staff never called their family member, a person living with dementia, by their chosen name. The auditing process had not picked up on this issue and addressed it with staff.
- The new manager had instigated various measures to try and improve the service. Staff told us that the manager was a visible presence in the service, carrying out spot checks and giving feedback. However, many of the serious concerns we identified had not been picked up either by this informal checking or by the provider's more formal auditing procedures.
- There were a number of formal audits in place, but actions did not always follow promptly. The concerns about the state of the building, which most staff commented negatively about, and which had been identified on our last two inspections, had still not been fully addressed. The poor state of disrepair in some areas posed a risk to the people who used the service and should have been a priority for the provider.
- The lack of oversight of the cleaning of the service and infection control practice was a major concern

given the current pandemic. Staff, including the manager, had become relaxed about basic infection control procedures such as mask wearing, cleaning and staff social distancing. Clear systems were not in place to protect people and audits and checks were not effective.

The quality and safety of the service had not been effectively assessed and monitored to mitigate risks. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

●Since our inspection staff have told us that issues we identified relating to infection control have been prioritised and practice has improved significantly. We have confirmed this by carrying out a further targeted inspection just to look at this issue.The provider has also devised some new systems designed to ensure that the required notifications are made in future.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; 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 had recognised that the quality of the service had been deteriorating in recent months and had put an experienced manager in post quickly when the registered manager left in June. People's relatives told us they were not all informed about the management changes. Four relatives were unaware that a new manager was in post and one told us they had repeatedly tried to speak with the manager unsuccessfully. However, one relative had requested a meeting as they were concerned about the level of care and were positive about the response from the new manager.

●Communication was not consistent and left some relatives anxious about their family members at a time when they had not been able to visit them due to the pandemic. We received very mixed feedback from relatives about routine communication. One person commented, "I always have to call and ask how [my relative] is otherwise no communication." Another person confirmed this saying, "I just get mixed messages and I am left wondering…. So many mixed messages I don't know what to think." However, others commented that they felt they were kept fully informed with one person saying, "They are very good at keeping me informed. Any issues, they call me straightaway." .

● Care staff and nursing staff were very positive about the impact the new manager had had in a short space of time. One staff member said, "I feel so much more supported" and another commented, "[The manager] is quite approachable and listens. [They] took on board my idea of care teams." Other staff also reflected that the manager had listened to their ideas and felt that their opinions counted. One said, "[The manager] is more approachable. All staff are being heard. [It] helps us do our job better."

● The manager understood their responsibilities regarding duty of candour and relatives had been informed appropriately when incidents occurred.

●The manager was open and transparent with us and recognised the task before them. We acknowledged the positive work they have already begun to undertake, including improvements to staffing, staff training, staff culture and the management of people's distressed behaviours. The serious concerns we identified at our inspection were acknowledged and the service provided us with initial assurances and an action plan demonstrating key steps they had taken and planned to take next. This response meant we did not feel we needed to take any urgent enforcement action to help drive improvement.

Working in partnership with others

●We found that the service could benefit from increased engagement with outside agencies and with other providers to share good practice and gain support. The service had worked well with local healthcare services during the pandemic and had maintained links with the local authority quality improvement team.

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 18 Registration Regulations 2009 Notifications of other incidents The provider failed to notify CQC as required. Regulation 18.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider failed to ensure people received safe care and treatment as risks, including those relating to the spread of infection, were not effectively assessed and minigated. Regulation 12 (1) (2) (a), (b) and (h).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The provider had failed to ensure premises were clean, suitable for the purpose for which they are being used and properly maintained. Regulation 15 (1) (a), (c) and (e).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to operate effective systems and processes to assess, monitor and improve the quality and safety of the service. Regulation 17 (1) (2) (a).