Care Worldwide (Bradford) Limited

Owlett Hall

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

About the service
Owlett Hall is a nursing home providing personal and nursing care to 49 people aged 65 and over at the time of the inspection. The service can support up to 57 people. Accommodation is provided across three floors, a residential floor, a general nursing floor and a nursing dementia floor. The service also provides 'Discharge to assess beds' a scheme whereby people are discharged from hospital, often at short notice into this setting to await further assessment of their care needs. This aims to free up hospital beds within the acute sector.

People's experience of using this service and what we found
Overall people and relatives provided positive feedback about the home and management. However, staff were not always effectively deployed on the Oak unit. The Oak unit provides nursing care for people living with dementia. This meant people's care needs were not always met in a timely way. There was also a lack of organisation and leadership on the unit. These issues were a barrier to the service providing good quality dementia care. We found better organisation and care on the other units. Safe recruitment procedures were in place.

Arrangements were in place for relatives to visit the home, supported by appropriate risk management measures. However, some improvements were needed to infection control practices. We noted appropriate precautions were not always taken when people were isolating. Some areas of the home needed to be cleaner.

Overall risks to people's health and safety were assessed and managed and people told us they felt safe in the home. Equipment and the premises were appropriately maintained. Appropriate action was taken to investigate safeguarding issues and incidents. We saw evidence of learning from incidents and adverse events. Overall, medicines were managed safely.

Staff morale was variable, and a number of staff said they felt people were not receiving high quality care as there were not enough staff or the service was not appropriately organised. Systems to assess, monitor and improve the service were not sufficiently robust as the service continued to be in breach of regulation. Whilst this was the case, a number of the issues we identified were known to the registered manager and a plan was in place to address them. Plans were in place to improve governance and leadership particularly on the Oak unit where the majority of issues were identified. We saw recent improvements had been made to the service including enhanced monitoring of nursing clinical skills and upskilling them in areas where there had previously been concerns about 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 requires improvement (published 4 February 2020). The service remains

rated requires improvement. This service has been rated requires improvement or inadequate for the last five consecutive inspections.

Why we inspected
We carried out an unannounced comprehensive inspection of this service on 19 November 2019. Breaches of legal requirements were found. The provider completed an action plan after the last inspection to show what they would do and by when to improve safety and governance within the service.

We undertook this focused inspection to check they had followed their action plan and to confirm they now met legal requirements. We had also received some concerns about staffing levels and staff morale. This report only covers our findings in relation to the Key Questions Safe and Well-led which contain those requirements and cover the concerns we had received prior to the inspection.

The ratings from the previous comprehensive inspection for those key questions not looked at on this occasion were used in calculating the overall rating at this inspection. The overall rating for the service has remained as requires improvement. This is based on the findings at this inspection.

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

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

Enforcement
We have identified breaches in relation to staffing deployment, infection control and good 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.

Follow up
We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the 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?

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.

See our well-led findings below.

Owlett Hall

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

Service and service type
Owlett Hall 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 had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
We gave the service 30 minutes notice of our arrival to help ensure we entered the service safely during the COVID-19 pandemic.

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.

During the inspection
The inspection took place between 18th and 24 May 2021. We visited the service on the 18th May 2021 and reviewed documentation and spoke with the registered manager remotely up until the 24 May 2021. We spoke with six people who used the service and five relatives about their experience of the care provided. We spoke with nine members of staff including the registered manager, nurses and care workers. We observed care and support within the unit.

We reviewed a range of records. This included elements of five people's care records and multiple medication records. We looked at three staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including audits and meetings.

After the inspection
We continued to seek clarification from the provider to validate evidence found.

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 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.

Staffing and recruitment
• Staff were not deployed effectively on the Oak Unit which meant people did not always receive timely care and support. We observed people who needed assistance were not always provided with it until we asked staff to intervene. Staff were not effectively monitoring some areas of the unit and when they were present, they did not always relieve people's distress. One person said "I need support, but no one comes. I need a buzzer to get the staff." Staff told us they did not always have time to provide high quality care and they thought staffing levels should be higher on the unit.

We identified this had an impact on some people's mood, dignity and welfare. Because staff were not deployed effectively, and people had to wait for assistance. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager was aware of some of these concerns and had organised additional training and support for staff. A new unit manager was being appointed to provide enhanced leadership and direction to the Oak unit.

• Safe recruitment procedures were in place to help ensure staff were of suitable character to work with vulnerable people.
• Staff were provided with training, and the majority of this had been kept up to date. There had been a recent focus on upskilling nursing staff through a clinical competency framework, checking core skills as well as providing enhanced training in some subjects such as diabetes and wound care.

Assessing risk, safety monitoring and management
• Overall, people and relatives said they thought safe care and support was provided. One relative said "Yes, [person's] safe and they wouldn't want to be anywhere else." Risks to people's health and safety were assessed and detailed care plans were in place which were subject to regular review. Nursing staff we spoke with were knowledgeable about clinical risks. Overall care records provided evidence people had received appropriate care interventions, although some people had to wait for assistance on Oak unit.
• We found equipment was used appropriately in line with care plans. However, on the Oak unit we also found some instances of care plans not being followed, for example one person had not been weighed weekly in line with their care plan and another person did not have their call bell in reach. We raised these issues with the registered manager to ensure they were addressed.
• Overall the premises was safely managed with the required checks undertaken. Work had been done to improve fire safety within the home and staff training and understanding of what to do in the event of a fire

had been a key priority for the management. Some furniture and carpets were tired, stained and damaged and a plan was in place to address this.

Systems and processes to safeguard people from the risk of abuse
• Systems were in place safeguarding people from the risk of abuse. People and relatives told us that people were safe from abuse in the home and staff we spoke with had received training in safeguarding and understood their responsibilities.
• Where incidents had occurred, we saw these had been logged and investigated and the service had liaised with the local authority safeguarding team where appropriate. Good oversight was maintained of safeguarding incidents and the actions taken by the registered manager.

Using medicines safely
At our last inspection the provider had failed to ensure medicines were managed in a safe or proper way. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 12.

• Medicine administration records were in place and were well completed indicating people were receiving their medicines as prescribed. However, whilst most medicines could be accounted for, we identified three cases where counts did not correspond to records kept. Action was taken to address this by the registered manager.
• Medicines were stored appropriately, and appropriate records were kept for Controlled drugs. Clear information and instruction was in place if people had complex medicine requirements to assist safe administration. Staff had received training in medicines management and had their competency to give medicines regularly assessed.
• Where medicines were given covertly, we saw this was done following a best interest decision and as a last resort, with the service liaising with the pharmacy to ensure it was given safely. However, one person's covert (hidden) medicines plan was overdue a review, we raised this with the registered manager to ensure it was addressed.

Preventing and controlling infection
• During the inspection we were told by a nurse that three people were isolating in line with COVID-19 guidance following a stay in hospital. However, staff were not fully aware of all these individuals and were not taking additional precautions, for example in terms of Personal Protective Equipment and reducing time spent in these people's rooms. There were no risk assessments or care plans in place for these individuals around reducing the risk of spread of COVID-19. We also found some communal areas of the home were not cleaned in a timely way, for example carpets, furniture and fittings.

We did not identify an impact on people, but there was an increased risk of infection if safe practices were not followed. Safe isolation procedures were not being followed and areas of the home were not sufficiently clean, this was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) 2014 regulations.

•Clear visiting protocols were in place to help ensure people were able to visit their relatives safely. In addition to indoor visiting with precautions in place, a visiting pod and garden visits increased visiting options. People were also encouraged to stay in touch with their relatives via video calls using the homes tablet computers.

• Testing regimes were in place for people and staff and in most cases risk assessments to support safe working practices in relation to infection control, aside from the management of people isolating.

Learning lessons when things go wrong
• A system was in place to record, investigate and learn from incidents. We reviewed incidents and saw robust records were kept, with logs in place to track actions and improvements. Overall, there had been a low number of incidents with no concerning trends or themes.
• The registered manager demonstrated they had put in place systems to improve the service and demonstrated a commitment to continuously improving the service, including responding quickly to issues we identified during the inspection. Improvements had been made to diabetes and pressure area care over the last year in response to safeguarding concerns.

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 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; Continuous learning and improving care

• Regulatory requirements were not being met by the provider, this was the fourth inspection in a row that there were breaches of regulation. This demonstrated the provider did not have systems in place to ensure a high quality service which ensured compliance with the regulations. At this inspection we identified breaches of regulations relating to staffing levels on the Oak unit and infection control, which should have been prevented from occurring.

• We noted some examples of care plans not being followed. For example, one person's care plan stated their call bell should be in reach but it was not, and another person was not being weighed in line with their care plan.

We identified some impacts on people's welfare on the Oak Unit. Because robust governance arrangements were not in place to ensure regulatory requirements were met, this was a breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) 2014 Regulations.

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

• At times, the Oak Unit was chaotic with a number of people becoming distressed and staff not available to assist them. We saw instances where people were not appropriately dressed which meant their dignity was not always upheld. We observed care was not always person-centred and did not always demonstrate good dementia care. Staff did not always have the time to provide people with good high-quality care to reduce distress. They told us morale was low on the unit, and that they believed the care and support provided needed to be improved. The registered manager was aware of these concerns and demonstrated they had a strategy in place to address.

• We found a better culture and deployment of staff in other areas of the home. Overall people and relatives provided positive feedback about the home. One person said "I enjoy being here. No one makes me feel uncomfortable. The staff are helpful we have coffee mornings. The office they say if you have a problem just call in or tell us." A relative said, "If [person] is not well the manager rings me and lets me know, they were on the ball with it and kept me updated."

• The registered manager demonstrated they had a clear vision to further improve the service, prioritising the Oak Unit and upskilling staff. A deputy manager had recently been appointed and a unit manager was being recruited for the Oak unit to provide greater oversight and monitoring of people's care 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
•Relatives told us the home liaised with them and informed them of any incidents or concerns. The registered manager was open and transparent with us about the limitations of the service, things that had gone wrong and how they were going to be addressed.
• We saw examples of clear learning following incidents and information had been clearly communicated to people.
• Since the last inspection we saw action had been taken to address some of the specific issues raised. For example, medicines were now better managed and care records were more robust. We found care plans to be detailed and person-centred and the new manager had ensured that good clinical information was recorded to guide nursing staff.
• A range of audits and checks were in place and used to drive improvement. Actions were added to a clear service improvement plan. We saw a number of improvements had been made by the new registered manager, there had been a strong focus on improving nursing skills within the home and evidence of learning from incidents and improving care.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
• People, relatives and staff were invited to provide feedback about the service through various mechanisms. This included care reviews, staff and resident meetings and staff and resident surveys. We saw results from surveys had been analysed and action taken to address any negative comments.

Working in partnership with others
•The registered manager demonstrated that good working relationships were in place with others including local health professionals and commissioning organisations. Links had been made with local community organisation, including schools, nurseries and the women's institute to provide activity and stimulation to residents. Whilst the COVID-19 pandemic had prevented some of this activity taking place, plans were in place to re-commence this.

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 12 HSCA RA Regulations 2014 Safe care and treatment (1) (2h) Safe infection control practices were not always followed and the home was not consistently clean and hygienic.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing (1) Sufficient quantities of suitably qualified staff were not always deployed within the home.

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
Treatment of disease, disorder or injury	(1) (2a) (2b) Systems to ensure compliance with regulatory requirements were not sufficiently robust. Systems to assess, monitor and improve the service were not suitable robust.

The enforcement action we took:

We issued a warning notice requiring the provider to be compliant with our regulations by 1 September 2021.