Oakwood Lodge Care Home Limited

# Oakwood Lodge

## Inspection report

20 Argyle Road
Ilford
Essex
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05 May 2023

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## Ratings

| Overall rating for this service | Inspected but not rated |
|---|---|

| | |
|---|---|
| Is the service safe? | **Inspected but not rated** |
| Is the service effective? | **Inspected but not rated** |
| Is the service well-led? | **Inspected but not rated** |

# Summary of findings

## Overall summary

About the service
Oakwood Lodge is a care home registered to accommodate and support up to eight people with mental health needs over two floors. At the time of the inspection, six people were living at the home.

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

At the time of the inspection, the location did not care or support for anyone with a learning disability or an autistic person. However, we assessed the care provision under Right Support, Right Care, Right Culture, as it is registered as a specialist service for this population group.

Right Support:
This was a targeted inspection that considered risks to people, whether their needs were assessed and how they were supported to eat and drink. Risks to people were assessed and monitored. Risk were recorded in people's care plans and regularly reviewed. There were infection prevention and control actions in place. People's needs were assessed so the service knew whether they could support those needs or not. People were supported to eat and drink as per their needs and choices.

Right Care:
This was a targeted inspection that considered whether there was sufficient staff, whether staff were trained appropriately and how staff recorded and shared people's ongoing care. There were enough staff to meet people's needs. Staff were trained to support people, including some specialist training, such as how to use a de-choker. Staff communicated effectively with each recording people's care, which could be shared with other health and social care professionals where appropriate.

Right Culture:
This was a targeted inspection that considered whether there were lessons learned when things went wrong, whether quality assurance measures were sufficient and whether staff and management understood their roles and were supported in them. Lessons were learned when things went wrong; incidents were recorded, and actions completed to keep people safe. There were quality assurance measures, such as audits, which the registered manager used to monitor the quality of care provided to people. Staff and management were clear about their roles and the provider supported staff following incidents.

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 (13 July 2022).

Why we inspected
We undertook this targeted inspection to check on a specific concern we had about the unexpected death of

someone using the service. The overall rating for the service has not changed following this targeted inspection and remains Good.

We use targeted inspections to follow up on Warning Notices or to check concerns. They do not look at an entire key question, only the part of the key question we are specifically concerned about. Targeted inspections do not change the rating from the previous inspection. This is because they do not assess all areas of a key question.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

Follow up
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?

**Inspected but not rated**

At our last inspection we rated this key question Requires Improvement. We have not reviewed the rating as we have not looked at all of the key question at this inspection.

### Is the service effective?

**Inspected but not rated**

At our last inspection we rated this key question Good. We have not reviewed the rating as we have not looked at all of the key question at this inspection.

### Is the service well-led?

**Inspected but not rated**

At our last inspection we rated this key question Good. We have not reviewed the rating as we have not looked at all of the key question at this inspection.

# Oakwood Lodge

**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.

This was a targeted inspection to check on a concern we had about the unexpected death of someone using the service.

Inspection team
The inspection was carried out by one inspector.

Service and service type
Oakwood Lodge 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 Lodge is a care home without 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 a registered manager in post.

Notice of inspection
We gave the service 24 hours' notice of the inspection. This was because the service is small and people are often out and we wanted to be sure there would be people at home to speak with us.

Inspection activity started on 4 May 2023 and ended on 4 May 2023. We visited the location's service on 4 May 2023.

What we did before 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
During the inspection we spoke with the registered manager, another registered manager who worked for the provider locally and was supporting the service with the inspection, 1 person and 1 staff member. We reviewed documents and records that related to people's care and the management of the service. We reviewed 2 care plans, which included risk assessments. We also looked at other documents such as medicine management, training and quality assurance records.

Inspected but not rated

# 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 this key question was rated requires improvement. We have not changed the rating as we have not looked at all of the safe key question at this inspection.

The purpose of this inspection was to check concerns relating to the unexpected death of someone using the service. We will assess the whole key question at the next comprehensive inspection of the service.

Assessing risk, safety monitoring and management

- Risks to people were assessed, monitored and managed. We completed this inspection due to the unexpected death of someone using the service. We wanted to make sure the provider had done all they could to keep that person safe and ensure other people using the service were not at risk of harm.
- Risks to people were recorded in their care plans and covered all aspects of their care. Following an incident at the service we wanted to check how people's health conditions and risks associated with them, were checked and monitored. We saw risks relating to people's specific health conditions were covered in their care plans and other risks relating to their health and well-being were also recorded.
- At the time of the inspection no other people using the service had risks related to choking. However, we looked at other people's risk assessments and saw risks to them had been assessed and were regularly reviewed. These included risks for behaviour, absconding and health conditions.
- There were personal evacuation plans in place for people in case of emergency. This meant the service had thought about the risks to people in the event of an incident, such as a fire, and thought about the best way to support people in such an occurrence. These were personalised and took into account people's specific conditions.

Staffing and recruitment

- There were sufficient staff to ensure people using the service were kept safe. We saw two staff monitored people's mealtimes to ensure they were kept safe. This meant 1 staff member could provide food and one could monitor people when they ate. One staff member told us, "One of us serves the food and the other one monitors people eating."

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
● There were arrangements in place so visitors could visit people at the service. Visitors were able to attend the service and meet with people during the day and or take them out should they wish to. The provider asked that notice was given of impending visits to ensure people were at home. We saw the visitors log and that visitors came and went.

Learning lessons when things go wrong
● Lessons were learnt when things went wrong. We saw incidents and accidents were recorded and actions identified by management to lessen re-occurrence.

Inspected but not rated

# Is the service effective?

## Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At our last inspection this key question was rated good. We have not changed the rating as we have not looked at all of the effective key question at this inspection.

The purpose of this inspection was to check concerns relating to the unexpected death of someone using the service. We will assess the whole key question at the next comprehensive inspection of the service.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● People's needs were assessed and regularly reviewed. People had their needs assessed by the provider before they began using the service. This was to ensure the service could meet their needs properly.
● People's preferences were also recorded at this time, so staff knew how people liked things done. Assessments were in line with the law, recording their protected characteristics, such as their race, religion and sexuality.

Staff support: induction, training, skills and experience
● Staff received an induction when they began to work for the employer and were trained how to fulfil their roles. This included shadowing an experienced member of staff.
● Staff received regular training to ensure they were aware of and knew how to do things within their job. Training we saw included basic life support and medicines administration.
● Staff received specialist training to support people with specific needs. We saw staff had received training in how to use a specialist equipment which would support people in the event of an emergency. The provider recently reviewed this training with all staff due to the unexpected death of someone using the service.
● Staff received 1 to 1 support from management and supervision. Staff met with management and discussed concerns, development and changes at the service. Following the recent incident of an unexpected death we saw that management had met with staff and provided support to them.

Supporting people to eat and drink enough to maintain a balanced diet
● People were supported to eat and drink and maintain a balanced diet. People's nutrition and hydration needs were recorded in their care plans. This included their preferences towards meal choices and also whether they had specific food related conditions such as diabetes. One person told us, "It's a good place to live, good food."
● People's food was stored correctly. We looked at people's food and saw that opened items were correctly labelled and food we checked were in date. Staff knew how to properly handle food as they were trained to do so.

Staff working with other agencies to provide consistent, effective, timely care
● Staff worked with other agencies to provide effective care. Staff recorded daily activities for each person in

logs. This information identified the person's activities and how staff had supported them if required. Staff were then able to share this information with each other at shift handover. This information could also be shared with other health and social care professionals where appropriate.

Inspected but not rated

# 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 this key question was rated good. We have not changed the rating as we have not looked at all of the well-led key question at this inspection.

The purpose of this inspection was to check concerns relating to the unexpected death of someone using the service. We will assess the whole key question at the next comprehensive inspection of the service.

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

- Quality assurance measures were in place to ensure people received person centred care. These included medicines, infection control and care plan audits. Care plans had been reviewed regularly.
- Management supported the staff team and were in turn, supported by the provider. Following a recent incident, we saw the registered manager had met with staff and provided them with positive feedback about how they had acted to try and prevent someone's death. The registered manager had also met with other registered managers who worked for the provider, and discussed the incident and whether there was anything which could have been done differently. This showed an open and positive culture where management sought to learn from incidents and improve care as a result.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- Managers and staff were clear about their roles. Staff had job descriptions and knew who to speak with should they have concerns. The registered manager knew they were responsible for quality performance and regulatory requirements. Following the recent incident with an unexpected death, they sent a notification to CQC, which is something they must do when this type of incident occurs.