Surrey Rest Homes Limited

Oak House Care Home

Inspection report

Oak House
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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
Oak House Care Home is a residential care home that provides accommodation and nursing or personal care for up to 16 people, many of whom have physical disabilities and are living with dementia. At the time of this inspection, 15 people were living at the service.

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

The risks associated with people's care was not always undertaken in a safe way. This included the risk of trips and falls and choking. Accidents and incidents were not analysed for trends and themes to prevent further occurrence. The recruitment for staff was not robust. There was information missing around staff's employment background and there was a lack of required references for the provider to consider the staff suitability for the role.

The provider and registered manager did not have a robust oversight of the care at the service. They had not identified the shortfalls that we had identified at the inspection. People and staff were complimentary about the registered manager and said they felt listened to. People told us they felt safe and that they received their medicines when needed.

Rating at last inspection
The last rating for this service was Good (published 3 May 2019).

Why we inspected
The inspection was prompted in part by concerns we received relating to infection and prevention control practices and safe care and treatment.

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.

We have found evidence that the provider needs to make improvements in relation to risks associated with people's care, the recruitment of staff and the lack of robust quality assurance. 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 House Care Home on our website at www.cqc.org.uk.

Enforcement

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.

For requirement actions of enforcement which we are able to publish at the time of the report being published. 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 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.

Details are in our well led findings below.

Oak House Care 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
Our inspection was completed by two inspectors.

Service and service type
Oak House Care 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.

The service had a manager registered with the Care Quality Commission. This means they and the Provider is legally responsible for how the service is run and for the quality and safety of the care provided.

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 who work with the service. The provider was 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
We spoke with six people who used the service about their experience of the care provided. We also observed care and interaction between people and staff. We spoke with five members of staff including the registered manager, care staff and the chef.

We reviewed a range of records including four care plans, multiple medication records, safeguarding records and incident and accidents. We reviewed a variety of records relating to the management of the service including staff recruitment files.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data, policies, quality assurance and audits.

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 Good. At this inspection this key question 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.

Assessing risk, safety monitoring and management; Preventing and controlling infections; Learning lessons when things go wrong;

- Prior to the inspection concerns were raised to us staff were not always wearing masks to reduce the risk of spreading Covid-19. The registered manager confirmed that staff had told them they had told a relative they did not always wear masks as they believed they did not need to if they had tested negative for Covid-19. Although we observed staff wearing masks, one member of staff had their mask below their nose meaning the effectiveness of the mask was reduced.
- Risks associated with people's care were not always managed in a safe way. One person was at risk of aspiration and the guidance in their care plan stated they needed to have a member of staff with them when eating and drinking. However, when we arrived at the service the person was alone in the dining room eating their breakfast. Although staff were able to tell us what they needed to do if the person started choking this information was not in their care plan.
- The same person had unaccounted weight loss over a period of five months and had been assessed as high risk of malnutrition. Staff were only weighing the person monthly so there may have been missed opportunities to manage their weight loss sooner. The person had been placed on a food and fluid chart to measure their intake. However, the amounts of food were not being recorded and often the note stated the person was refusing meals. There was no evidence that this was being followed by staff.
- We observed a member of staff place a spoonful of food in a person's mouth despite the person telling them they did not want anything. The person closed their eyes and the member of staff placed a spoonful of food in their mouth when they were not expecting this. This could have caused the person to choke. We fed this back to the registered manager who told us they would address this with the member of staff.
- The registered manager told us there were people at risk of falls however this was not always being managed in a safe way which put people at risk. There were people that required walking frames. We saw staff placed these out of reach of people. On one occasion a person got up from their chair when no staff were present and attempted to walk without their frame as it was out of reach.
- We observed that a member of staff had mopped the lounge floor whilst people were sat in there and placed warning signs. This did not prevent a person standing up and walking on the wet floor which was slippery. We intervened and called a member of staff to support them. The registered manager told us they would ensure the floors would not be mopped whilst people were in there unless an incident of spillage had occurred.
- There were hoists and boxes being stored in the dining room which was a trip hazard to people. We also observed a member of staff left a mop and bucket and cleaning materials in the corridor next to rooms that people accessed.
- One person had been admitted to the service two weeks prior our visit. There was information in their

notes the person was at risk of falls and had fallen prior to moving in. There was no falls risk assessment in place for the person.
● Accidents and incidents did not always have detailed information recorded on the actions taken to reduce further occurrence. For example, according to an incident report a person had lost balance and fallen and was complaining of pain in the afternoon. There was no clear documented action as to whether anything had been done to prevent this from occurring again.
● On another occasion a person had sustained a skin tear and a district nurse was needed to dress the wound. There was nothing in the incident report on what preventative measures actions had been taken.
● We were provided with evidence after the inspection of actions taken as a result of the incidents.

The failure to not always manage risks associated with people's care in a safe way is a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

● After the inspection the registered manager provided us with photo evidence that the dining room had been cleared of the boxes. They also showed us evidence of new accident and incident forms where more detail could be added around actions taken.
● We were assured that the provider was meeting shielding and social distancing rules.
● We were assured that the provider was admitting people safely to the service.
● We were assured that the provider was accessing testing for people using the service and staff. Visitors were able to visit people without restriction.
● 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.
● There were Personal Evacuation Plans (PEEPS) in place for people with details around how they needed to be supported in the event of an emergency.

Staffing and recruitment
● The provider failed to operate safe and effective recruitment practices when employing new staff. We found they lacked full employment histories for all three of the staff files we reviewed. For one member of staff it stated one of the previous employments but there were no dates included for this.
● According to their policy the provider was required to have two references for staff however there was only one reference for one of the members of staff. One reference for a member of staff was from their friend. This did not provide sufficient evidence for the provider to make an assessment about the member of staff's character or suitability for the role.

As the recruitment procedures to ensure that staff employed were fit and proper this is a breach of regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● There was evidence of disclosure and barring service (DBS) checks. DBS checks are carried out to confirm whether prospective new staff had a criminal record or were barred from working with people. Staff had also provided evidence of their identity.
● People we spoke with told us there were enough staff to support them. Comments included, "I just press my alarm and staff come quickly", "There's always enough staff" and "There's always someone to help you when you need it."
● There were sufficient numbers of staff to meet people's needs. Staff attended to people's needs without them having to wait. The registered manager informed us that they did not need to use agency staff and that safe staff levels were always maintained. The registered manager assessed people's dependency regularly and increased the staffing levels where needed. They said, "At the moment the staff team is quite stable."

● Staff fed back there were enough staff to support people. Comments included. "There's plenty of staff" and "There's always enough staff. We are never short staffed."

Using medicines safely

● People told us they received their medicines with one person saying, "They help me with my medicines, I get all the help I need."

● There were appropriate systems in place to ensure the safe storage and administration of medicines. People's medicines were recorded in all the medication administration records (MAR) with a dated picture of the person and details of allergies, and other appropriate information for example if the person had swallowing difficulties.

● There were medicines prescribed on 'as required' (PRN) basis and these had protocols for their use. We saw that staff checked people's blood sugar levels where the person had diabetes.

●The medicine audit was undertaken regularly, and all staff had been competency assessed to ensure that they had the skills required to administer medicines.

Systems and processes to safeguard people from the risk of abuse

● People told us they felt safe at the service. One person said, "Staff are very sweet, they work so hard. So kind to me."

● The registered manager ensured that staff understood safeguarding adults procedures and what to do if they suspected any type of abuse. There were people at the service who were unable to verbally communicate, and the registered manager ensured staff looked for signs of any abuse occurring. One member of staff said, "[We] report anything if we see it, like if we saw something we didn't agree with."

● There was a safeguarding adults policy and staff had received training in safeguarding people. One member of staff told us, "We get safeguarding training, so we look at different abuse to know what to look out for."

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 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

- The provider and registered manager had failed to ensure robust oversight of care at the service. Prior to the inspection we were made aware that staff had had been witnessed on several occasions not wearing their face masks. The registered manager told us they had also been made aware of this. However, they had not taken robust steps to address this from the first instance they were made aware and staff continued to be found on occasion to not be wearing their face masks.
- There were staff practices at the service that were not safe, but this had not been identified as unsafe by the provider or registered manager. This included staff mopping the floors in the communal areas which was a trip hazard to people and people's walking frames being moved out of reach. We discussed this with the registered manager who acknowledged that on reflection this should not have been happening.
- Although audits were taking place, they were not always effective in identifying shortfalls at the service. For example, we identified gaps in the recruitment records for staff and trips hazards caused by the storing of equipment in the communal areas. We saw provider audits had taken place where no concerns were recorded for both of these areas.
- The registered manager had taken a decision to admit three people to the service in quick succession in the same week. They told us, "I felt pressure to admit them as soon as we were allowed to." They confirmed to us that the risk assessments and care plans had not been fully completed for two of the people although the registered manager told us staff had been made aware of their needs. However, the lack of assessing each person's risks associated with their care meant that staff may not be fully aware of the care required and associated risks for people.
- The registered manager was newly appointed and there had been a period of time where there had been no permanent manager at the service. The registered manager told us this had impacted on the oversight of care. They also told us they were still adjusting to their role of registered manager at the service as they had previously been a training provider there.

As systems or processes were not established and operated effectively to ensure compliance with the requirements this is a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- People were complimentary of the registered manager. Comments included, "She's very nice, very approachable. She's always around if you have a question. I would go to her if I had a problem, "She's lovely,

a very warm person" and "I think she's fine, I'm sure she would try to sort something out if I had a problem."

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● People were given opportunities to talk about things they would like at the service through seeking feedback. One person, told us, "I asked them for a bell (in the lounge) and within 24 hours I had this chord installed." Resident meetings took place where people were asked about menus, activities and care from staff. We saw from the minutes there was positive feedback from people.

● Relatives and visiting health care professionals were asked to complete surveys to review the quality of care. There were positive comments on the surveys which included, "Extremely well run. The staff are caring and always have time" and "Wonderful staff."

● Staff had the opportunity to contribute positively to the day to day running of the home. One member of staff said, "[The registered manager] she is very good, she will always listen." Another told us, "We can just speak to them [management] in staff meetings."

● Staff told us that they felt listened to and appreciated. Comments included, "I am 100% supported" and "If I want feedback I ask, the manager is so approachable."

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; Working in partnership with others

● We saw from the records the registered manager worked closely with health care professionals in support of people's care. The registered manager told us, "We work with GPs, organise any referrals. We have district nurses that administer insulin. We have mental health team. Opticians and chiropodist and physiotherapist and dentist. Lots of external agencies."

● We saw from the records that relatives had been contacted where there had been an incident with their family member. The registered manager told us, "If we make any mistakes, we need to be open and honest and transparent."

● Services that provide health and social care to people are required to inform the Care Quality Commission (CQC) of important events that happen in the service. The provider had informed the CQC of significant events including incidents and safeguarding concerns.

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 The provider failed to always manage risks associated with people's care in a safe way

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to ensure systems or processes were established and operated effectively to ensure compliance with requirements.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider failed to ensure recruitment procedures were robust to ensure that staff employed were fit and proper.