New Century Care (Colchester) Limited

The Oaks Care Home

Inspection report

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21 November 2022
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28 November 2022
14 December 2022

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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
The Oaks Care Home is registered to provide accommodation, personal and nursing care for up to 61 people who may have a physical disability, living with dementia, or requiring end of life care. At the time of our inspection 48 people lived at the service.

People's experience of using this service and what we found
Improvements were needed in the management of medicines to reduce the risk of errors being made, and to ensure all people receive their medicines as prescribed.

Staff were not always following safe infection control processes. Improvements were needed to ensure all areas of the service and equipment used were kept clean and hygienic.

Governance systems were not robust enough to ensure shortfalls were independently identified and addressed.

People told us they felt safe living in the service and if they had any concerns knew to who to talk to. One person said, "I like it here…I feel very safe," and told us if they had a concern they would, "Speak to the nurse or [manager]."

Feedback from people living in the service, their relatives and staff identified at times the provider's staffing levels were not being maintained. This impacted on staff being able to spend time talking with people. The manager was aware how a high level of sickness would affect maintaining the planned staffing levels and was taking action to address it.

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. However, if staffing levels are not maintained, this could have an impact on people's choice, and being able to take part in activities.

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 24 January 2018).

Why we inspected
We received concerns in relation to the management of medicines and governance of the service. As a result, we undertook a focused inspection to review the key questions of safe and well-led only. For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating.

The overall rating for the service has changed from good to requires improvement based on the findings of 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 COVID-19 and other infection outbreaks effectively.

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

The provider responded immediately during and after the inspection, carrying out a full medicines audit and producing an action plan to address concerns.

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

Enforcement
We have identified breaches in relation to medicines management and quality assurances systems 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 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.

The Oaks 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 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
The inspection team was made up of 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
The Oaks 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. The Oaks 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 started in September 2022 and had applied to register. We are currently assessing this application.

Notice of inspection

This inspection was unannounced. Inspection activity started on 21 November 2022 and ended on 14 December 2022. We visited the service unannounced on the 21, 23 and 28 November 2022.

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 7 people living in the service and 13 people's relatives. We also spoke with 12 staff which included the manager, nurses, care assistants, well-being coordinator, and ancillary staff. We reviewed a range of records. This included medicines records, incident and investigation reports, risk assessments and records relating to 10 people's care. We also reviewed 3 staff recruitment records, staff rosters, staff training records and records relating to the quality assurance of the service, including audits, and minutes of meetings.

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 an increased risk that people could be harmed.

Using medicines safely

● Shortfalls were identified in the ordering, storing, administration and record keeping of medicines, which put some people at risk of not receiving their medicines as prescribed.

● Where out of date insulin and eye drops were given, and where medicines had not been stored at the correct temperature, this might have an adverse effect on their effectiveness.

● Medicines were administered using an electronic medicines administration (e-MAR) system which supported staff to follow the prescriber's instruction. However, this was not always accurate and did not contain information such as flagging when people were taking covert medicines. (These are medicines hidden in food and fluids).

● Medicines were not always available when people needed them which had resulted in people missing their medicines. There were excess medicines stored at the service and stock counts on the e-MAR system did not always tally with the physical stock count. The e-MAR system did not always record accurately when and what medicines people had taken.

● People who were prescribed time-sensitive medicines for the treatment of Parkinson's disease did not always get these at the correct times. Failure to administer these medicines as prescribed could result in the person experiencing unwanted symptoms and a deterioration in their condition.

● The service was not performing the quality assurance check of calibration for its blood glucose diagnostic equipment for diabetic care management. People's diabetic care plans, where they were in place, did not contain any information relating the person's dose of insulin, what their blood sugar levels should be or information regarding hypoglycaemia and hyperglycaemia.

The management of risk and medicines was ineffective and placed people at risk of harm. This demonstrates a breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider and management took immediate action on our findings, carrying out their own audit and sending CQC an action plan to address the failures.

● Four people's relatives told us the nursing staff were very good in keeping them updated on any change in their relative's medicines. One person told us nurses, "Are really good at keeping me updated on all changes." Another said, "They inform me of any change."

Preventing and controlling infection

● Improvements were needed in the service's infection control, to ensure people were constantly supported in a clean and hygienic environment. In one sluice room and bathroom, we found equipment contaminated

with bodily fluids, which had not been effectively cleaned, or where applicable, disposed of. Areas of the floor in the sluice room were cluttered, which impacted on the floor being effectively cleaned.
● Although staff had received training in the correct use of personal protective equipment (PPE), during the inspection 2 staff's face masks were not covering their nose. Action was taken during the inspection to remind staff to ensure they wore PPE correctly.
● Throughout the inspection housekeeping staff had a visible presence. One person said they were happy with the cleanliness of their bedroom, which was very personalised. They told us, "Every day," staff cleaned their bedroom.
● There were cleaning schedules in place to ensure people's bedrooms, visitors' toilets and shared spaces such as the dining room and lounges were kept clean. Staff told us each person had their bedroom, "Deep cleaned," once a month, or earlier if needed.

Visiting in care homes
● One person said they were waiting for their visitors to arrive, and that there was, "No problems with visiting." Relatives felt the service had good flexibility around visiting. One relative told us, "No restrictions now, I am in and out all the time."
● However, 3 people's relatives mentioned visiting was between, "11am and 4pm," with 1 saying they felt very frustrated, "As I would like to drop in after work but can't." The manager said they encouraged visiting during 11am to 4pm, when the reception staff were on duty, but people could visit outside these times. To clarify the situation, the manager said they had sent out emails to people's relatives, and it would also be discussed at the next relative meeting.

Staffing and recruitment
● People, their relatives and staff, gave us mixed feedback on there being enough staff. One person told us, "Staff haven't got the time to just sit and talk." Comments from relatives ranged from, "I think they are short staffed, and I think this impacts on [the person's] care," as they were left for long periods on their own. To, "There always seem to be someone [staff] about."
●The provider used a dependency tool to support them in setting staffing levels. Staff felt when fully staffed, they had the time needed to provide quality care, but this was not always happening. The manager described the actions they were taking to address the situation, which included improvements in monitoring staff sickness and using a staff social media site to assist them in covering last minute sickness.
● One staff member described staffing levels as being, "Erratic," caused through the high level of staff sickness. Another said when short staffed, they, "Pulled together," to ensure people were safe, but it impacted on their ability to spend time talking with people.
● Staff were recruited safely. This included proof of identity and checks through the Disclosure and Barring Service (DBS) before employing new staff. The DBS helps employers make safer recruitment decisions.

Systems and processes to safeguard people from the risk of abuse
● People told us they felt safe, and if they had a concern, they would tell someone. One person told us if they had a concern, "I would report it." But had not needed to as they liked the staff. Another commented, "I would speak to the nurse or [manager]," if they had any concerns.
● A relative said, "I trust the nursing and care staff totally."
● Staff had training on how to recognise and report abuse and they knew how to apply it.
● Where a safeguarding incident had occurred, the service worked with the CQC and other agencies to ensure people's safety and well-being.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong
● Risk assessments in people's care plans provided clear guidance to staff on supporting people to keep

safe. This included information to reduce the risk of falls, choking, and not drinking enough to keep hydrated.

● One person told us they were determined to retain their independence as much as possible, "Don't want to give in." Therefore, rather than staff automatically providing assistance, the person asked for help when needed. One person's relative said, "The staff are amazing, they do their absolute best," to monitor their family member's welfare and keep them safe.

● A staff member demonstrated how they monitored each person's fluid intake on their electronic handset. If they noted a person had not reached their expected daily intake, they would monitor the situation and encourage / support the person to drink more.

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. However, improvements were needed.

● Staff only used disguised medicines in food / fluid as a last resort. Paperwork had been completed to show who had been involved in the decision and a pharmacist had reviewed the medicines. However, they had not routinely updated the person's DoLs to reflect this. A staff member said they were in the process of reviewing all the MCA information, and will ensure any DoLs are updated.

● Staff understood the importance of assessing whether a person had a specific decision and the process they would follow if they lacked capacity.

● Relatives told us people were supported to make their own decisions. However, where the person lacked capacity to make a particular decision, for example regarding medical treatment, staff ensured the person's relative was fully involved. One relative told us, "Nursing staff phone me and discuss."

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; 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; Continuous learning and improving care

- The arrangements to assess and monitor the quality of the service were not effective enough. The range of checks and audits carried out by internal and external management had failed to pick up our concerns around the safe management of medicines and infection control.
- The provider had notified the CQC of medicine errors. However, they had not demonstrated a lesson learnt approach in reducing risk. Staff were not completing medicines audits. There was a lack of oversight of the medicines processes at the service by the manager.
- Information was not disposed of in line with the General Data Protection Regulation (GDPR). A general waste bin contained empty boxes of medicines with person identifiable information.
- Following our previous inspection on infection prevention and control on 23 February 2021, the provider told us, 'more robust checks had been put in place,' to ensure the sluice rooms were kept decluttered and clean. During this inspection we identified some of the same shortfalls, it demonstrated the checks put in place were not effective.

Systems were not robust enough to evidence effective oversight of the service. This demonstrated a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

- At the time of the inspection, a new manager was in post, and had submitted their application to be registered with the CQC. The manager had experience in the role and what was expected of them. One person said the manager had, "Not been here long but so far okay."

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

- Relatives provided examples of what the service did well. One told us, "The fundamental nursing care, which is skilled and compassionate, and the activities coordinators are very good." Another said, "Entertainment staff are excellent." Two relatives said, "Staff are lovely."
- Where some relatives felt happy to recommend the service, one relative told us, "Without hesitation," another saying, "Yes, I would." Others said they wouldn't at the current time. One relative commented, "Not at the moment," another said, "At present probably not, we wait and see what the new manager is like."
- Significant changes both at management level and at the senior level of the organisation had occurred,

especially since February 2022.
● Some relatives felt the changes had not been communicated well and saw communication as an area of improvement. One relative commented, "The actual care is good, the communication is terrible." Another said, "Communication has deteriorated, it is very difficult… if you get through to someone it is difficult to follow up on queries."
● The provider had a clear vision for the direction of the service which demonstrated ambition and a desire for people to achieve the best outcomes possible.
● As part of their vision, which would also aid communication, the provider was in the process of piloting a system in another of their services. If the pilot was successful, they would look to introducing a 'family portal' at this service. The portal allowed a person's relative/advocate, with the person's consent, to 'log in' and access care records to see what care intervention the person had received.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
●The provider used different forums to gain feedback on the quality of the service received, and influence change. This included resident, relative and staff meetings, quality feedback surveys, the 'Oaks' newsletter,' care reviews and email updates.
● The staff meetings carried out during the inspection activity enabled the management to update staff on CQC's findings, listen to what staff had to say, and use feedback to drive improvements. One staff member told us the new manager, "Will listen," but it would take time to make all the required changes.
● The provider was in the process of sending out their 2022 resident and relative feedback questionnaires. The results of the 2021 'You said, we did' questionnaires were displayed in the service. This included each person receiving copy of the weekly activities programme. One person showed us their copy, which helped them decide which activities they wanted to attend.
● Relatives told us they felt comfortable to raise any concerns. One relative said, "I raise concerns whenever I have them," and told us what action had been taken to address their concerns.

Working in partnership with others
● Information in people's care records and discussions with staff showed the service worked closely with others, for example specialist dementia teams to support care provision.

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 management of risk and medicines was ineffective and placed people at risk of harm.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems were not robust enough to evidence effective oversight of the service.