Calton Systems Limited

Oaklands House

Inspection report

119 Rochdale Road
Milnrow
Rochdale
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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
Oaklands House is in Milnrow, Rochdale and consists of a large period building that has been extended to provide 13 single bedrooms for people who are diagnosed with mental health problems and are over the age of 18 years. There were 13 people living at the home at the time of inspection.

People's experience of using this service and what we found
The risk to people's safety was not always well managed. We found there were areas of concern in relation to fire safety and the maintenance of the premises which put people at risk of harm.

There was no clear auditing process in place and policies and procedures were not available at the time of the inspection. There was a lack of auditing across the service which put people at risk of harm as it was not clear what oversight the provider had when things went wrong or people's needs changed. We received some policies after the inspection, relating to medicines and safeguarding however not all of the information requested from the service was made available.

The recruitment of staff was not always robust and appropriate background checks of staff were not taking place prior to them starting work. People's medicines were not always appropriately managed and the process for identifying medication errors was not robust.

People told us the management team were approachable and would address concerns. The manager at the home was in the process of applying to the post of registered manager. The person applying to be the registered with the Care Quality Commission as registered manager, will be referred to as 'the manager' throughout this report.

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 16 April 2018).

Why we inspected
The inspection was prompted in part due to concerns received about staffing and safeguarding management. 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 therefore we did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.
The overall rating for the service has changed from good to requires improvement. This is based on the

findings at this inspection.

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

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.

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 monitor the service and to hold providers to account where it is necessary for us to do so.

We have identified three breaches of regulation. These relate to the medicines management and recruitment (Regulation 12, Safe care and Treatment), the safe maintenance of the premises (Regulation 15, Premises and equipment) and the systems for oversight were not sufficiently robust to have identified all of the issues we identified (Regulation 17 Good Governance) at this inspection.

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

Oaklands House

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 undertaken by one inspector with two days on site.

Service and service type
Oaklands House 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 in post however they were not registered with the Care Quality Commission at the time of inspection. A registered manager is a person who along with 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 and professionals who work with the service. We contacted Healthwatch for feedback on care in relation to this service. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England.

We used all of this information to plan our inspection.

During the inspection
We spoke with five people who used the service about their experience of the care provided. We spoke with eight members of staff including the provider, the manager and care workers.

We reviewed a range of records. This included three people's care records and multiple medication records. We looked at three staff files in relation to recruitment and training.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data and quality assurance records. We spoke with staff over the telephone to gather more information about the service.

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 now deteriorated 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

● Systems and processes were not in place to ensure people were safe. There were overdue electrical works which required action and a prompt response to remedy these faults had not been sought by the provider.

● There was no evidence water checks for legionella were taking place and there was no environmental risk assessment available.

At this inspection we found that maintenance within the home was not being carried out appropriately. This was a breach of regulation 15 (Premises and Equipment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● There was no fire risk assessment available at the time of inspection. On the second day of inspection, an external company attended the home and completed an assessment, which highlighted a number of concerns in relation to fire safety. Following inspection, the home had taken action to make changes within the home, to improve safety.

● The provider had not ensured staff recorded building and fire safety checks. At the time of inspection, there was no fire evacuation plan for people living at the home and the fire alarm was not routinely tested. This put people at risk of harm. This was addressed after the inspection and the home received support from the local fire service.
● The provider did not have an audit process to ensure maintenance checks were completed therefore safety issues had been left unnoticed.
● Staff had assessed people's needs, however there was no clear process for review when a person's need changed. One person living in the home did not have a care plan in place.

We found no evidence that people had been harmed however, systems were either not in place or robust systems to demonstrate there was oversight of the service. This placed people at risk of harm. This is a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely, Staffing and recruitment

● Medicines were not managed safely. People who were prescribed medicines to be given at a specific time did not receive their medicines in line with guidance.
● There was no clear process for recording of medicines errors and there was no evidence that medicines

were being audited to identify any errors occurring.
● For medicines to be taken as needed (PRN), there was no clear protocol for staff to follow for when to give this medication. Following inspection, the PRN protocols were put in place for people prescribed these medicines.
● There was no clear process for identifying medicines errors and the documentation available did not reflect all medication errors that had happened. There was no auditing process for medication at the time of inspection however the manager was in the process of implementing a new medication auditing tool.
● Recruitment of staff was not appropriately managed. One person was working at the home without appropriate background checks in place and had not completed an induction or mandatory training prior to working unsupervised.

We found no evidence that people had been harmed however, systems were either not in place or robust enough to demonstrate safety was effectively managed. This placed people at risk of harm. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Training records were not available at the time of inspection and the training matrix did not reflect training completed by staff. Evidence of completed training was supplied after the inspection.
● People told us they liked the staff and that they could support their needs. One person said ''the staff are wonderful'' and "I really like living here".
● The manager was in the process of auditing the staff files and had highlight some shortfalls in the staff records.
● There was no risk assessment in place for staff who worked alone in the building at night.

We recommend the home complete a risk assessment for lone working staff to seek assurances that staff are appropriately protected from harm.

Systems and processes to safeguard people from the risk of abuse, Learning lessons when things go wrong
● Staff told us they knew how to keep people safe. The majority, although not all staff, had completed training in safeguarding adults. Staff told us they felt confident to raise concerns with the manager and that action would be taken to protect people.
● There was no clear process for recording safeguarding incidents within the home at the time of inspection. Where incidents had occurred, it was not always clear what follow up action had been taken or whether the incident had been investigated. There was no incidents and accidents policy available at the time of inspection.
● There was no evidence of regular auditing of records including accidents and incidents, medicines, supervisions and safety records, resulting in a lack of oversight by the provider.
● There was limited evidence of lessons being learned across the service. We saw some evidence of medicines error recording, however this did not correlate with actual medication errors that had occurred.

We found no evidence that people had been harmed however, systems were either not in place or robust enough to demonstrate safety was effectively managed. This placed people at risk of harm. This was a further breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 meeting shielding and social distancing rules.

● We were somewhat assured that the provider was admitting people safely to the service.
● We were somewhat assured that the provider was using PPE effectively and safely.
● We were assured that the provider was accessing testing for people using the service and staff.
● We were somewhat 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.
● We were assured the provider was facilitating visits for people living in the home in accordance with the current guidance.

There was no admissions policy available at the time of inspection, to detail how new residents would be safely admitted into the home.
On the first day of inspection, staff were not wearing personal protective equipment i.e. masks, this was resolved by the second day of inspection.
The staff told us there was increased cleaning in the home of touchpoint areas however this was not documented in the cleaning records.
The service had not completed risk assessments for staff to determine whether they were more at risk if they contracted Covid-19.

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 good. At this inspection this key question has now deteriorated 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

- The manager was in the process of applying to register with the Care Quality Commission to the role of registered manager at the time of the inspection.
- There was a lack of evidence that audits were being completed by the home and it was not clear what oversight the manager and provider had of the service. There were two audits available at the time of inspection. One audit identified a number of shortfalls at the service including that comprehensive auditing of records across the service needed to be implemented.
- At the time of inspection, the policies and procedures necessary to support good governance in the home were not available.

We found no evidence that people had been harmed however, systems were either not in place or robust enough to demonstrate there was oversight of the service. This placed people at risk of harm. This is a further breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The manager told us they were committed to making changes at the home and had taken action to address some of our concerns by the second day of inspection. The manager was in the process of creating an action plan to identify shortfalls across the service.

Continuous learning and improving care; Working in partnership with others, 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 reporting of accidents and incidents within the home was not comprehensive and it was not clear whether the appropriate referrals had been made.
- There was evidence that CQC had not been notified when incidents had occurred within the home.
- Some staff told us they had requested additional training or had training identified following an incident, but that the refresher training did not take place.

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

● There was some evidence that people had been consulted on events within the home, including changes to guidance around Covid-19 restrictions.
● People at the service were able to ask for support however there was limited documentation available to suggest changes had been made as a result of people's preferences.
● There had been a changeover in management recently at the home and it could not be established through documentation that staff and resident meetings had been taking place within the last 6 months. The manager had focussed on familiarising themselves individually with people living at the home and was in the process of arranging resident and staff meetings once more.
● Staff talked positively about working in the home and were enthusiastic about the manager who was new to the service. One person told us "when you go to her (the manager) with a problem, she'll help you find a solution''.

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 Medicines were not managed safely and the recruitment of staff was not appropriately managed.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The premise was not being maintained appropriately to ensure people were safe from harm.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The systems for oversight were not sufficiently robust to have identified all of the issues we found on inspection.