Oakdene Sleaford Limited

Oakdene Care Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Oakdene Care Home is a care home providing personal and nursing care for up to 35 people. The service provided support to older people with a mixture of physical and mental health needs. At the time of our inspection there were 29 people using the service. One of these people did not receive support with the regulated activity 'personal care.' We therefore did not consider their records when making our judgements.

People's experience of using this service and what we found
People did not receive safe care. This is because care staff did not have enough written guidance or training to complete their role safely. Concerns with the environment were not managed safely. The emergency buzzer system could not always be heard, so did not allow a timely response from staff. People were at risk from getting trapped in bed rails.

Hoist slings (used to lift people to aid moving to a new position) were damaged. This risked causing injury, by failing when in use. Topical creams were not stored or recorded appropriately, and staff did not always record why, 'as needed' medicines were given. The home was not always clean, leaving people at risk from the spread of infection.

Staff did not use nationally recognised risk assessments effectively. People received enough to eat and drink, but kitchen staff did not have enough training to understand how to prepare altered texture diets effectively. Visiting professionals' advice was recorded, however this hadn't always been followed.

People were not supported to have maximum choice and control of their lives. This meant staff may not support them in the least restrictive way possible and in their best interests. The policies and systems in the service did not support more effective practice.

There was poor oversight of the service. When risks were raised, there had been a failure to take timely and effective action. This poor management had left people at risk of harm. A new manager had been employed but had only been in position for a week, so their work was not yet embedded at 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 good (published 21 March 2018).

Why we inspected
The inspection was prompted in part due to concerns received about staff training, unsafe moving and handling, bed rails, and cleanliness. The local authority had also completed an audit in November 2022 and identified some concerns about safety at the care home. A decision was made for us to inspect and examine those risks.

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.

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 inadequate based on the findings of this inspection. We have found evidence that the provider needs to make improvements. Please see the safe, effective and well led sections of this 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 Oakdene Care Home on our website at www.cqc.org.uk.

Enforcement
We have identified breaches in relation to consent, safe care and treatment and good governance.

Details of what action we have taken can found at the end of the inspection 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 overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe, and there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions of their registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it, and it is no longer rated as inadequate for any of the five key questions, it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.
Details are in our safe findings below.

Is the service effective?

Inadequate

The service was not effective.
Details are in our effective findings below.

Is the service well-led?

Inadequate

The service was not well led
Details are in our well led findings below.

Oakdene 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.

Inspection team
The inspection was completed by 3 inspectors, a specialist advisor (a nurse) 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
Oakdene Care Home is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement. This is dependent on their registration with us. Oakdene Care Home 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 the registered manager had left employment a week before. A new manager was in position and advised us they intend to be the registered manager for the service. However, at the time of the inspection there was no registered manager in place.

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 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 9 people and 7 relatives about the care provided. We spoke with 6 care/nursing staff. We spoke with the manager and nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider. We reviewed 12 people's care plans and 7 people's medicine records. We looked at records related to audits, 3 staff recruitment files and staff training documents. We also reviewed some of the provider's policies which were in place.

Inadequate

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 inadequate. This meant people were not safe and were at risk of avoidable harm.

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

● People did not always receive a timely response from staff in an emergency. People were given buzzers to press if they required staff support, but the buzzer system could not be heard in all parts of the care home. For example, the inspector found a person requiring urgent support and pressed the call buzzer. Staff nearby could not hear the buzzer and did not respond until the inspector left the person's bedroom to call staff over. This increased the risk that a person may not receive support when they needed it.

● People's care plans and risk assessments were not kept up to date to keep people safe from harm. For example, one person was known to smoke alone. We saw they had burn marks on their clothing and wore highly flammable body cream. Appropriate action had not been taken to ensure they were kept safe from the risk of burning themselves.

● Bed rails were not safely fitted. There were unsafe gaps and people told us that this meant they needed to be careful to not get their legs and arms trapped. One person showed the inspector a gap between the mattress and bed rail that they could be trapped in. They explained that staff had pushed a pillow in the gap to reduce the risk. This was not an appropriate response to reduce the risk. The local authority had raised concerns about bed rails to the registered manager in their November 2022 audit. When we inspected in January 2023 suitable action had not been taken to improve bed rail safety. This meant people continued to be at risk of harm.

● Equipment was not safely maintained. On the first inspection day, we saw that slings used to lift people in the hoist were frayed and damaged. This damage risks the sling failing while being used which could cause serious injury to the person. This risk was explained to the management team. When the inspector returned 2 days later, they were informed that damaged slings had been removed from the property. However, the inspector observed a damaged sling was still in a person's bedroom. This failure to remove all damaged slings from the building left the person at increased risk of potential harm.

● The provider did not take suitable action to improve legionella safety at the care home. Legionella is an infectious waterborne disease that can cause serious ill health. Risk assessments identified what safe temperatures water should be, to reduce the risk of legionella bacteria build up. Whilst, the water temperatures had been regularly checked; there was no evidence that action was taken when the water was found to be outside of the safe temperature ranges. This meant there was an increased risk of potential legionella infection.

● Plumbing pipes around the care home were unshielded and were hot to the touch. This caused a potential burning risk to people. For example, 2 pipe's surface temperatures were checked . The surface temperatures of those pipes was found to be 46 and 59 degrees Celsius. This is above the health and safety guidance of 43 degrees maximum temperature and poses a high risk of people burning themselves if they came into contact with the surface of the pipes.

●People's personal evacuation plans were not stored in a single accessible place. Personal evacuation plans

are used by staff and emergency services to identify the support needed for each individual to evacuate the building in an emergency. This could potentially hamper the safe evacuation of people in the event of an emergency.
● Incidents were not reviewed to ensure care was improved. We saw records which showed 1 person had fallen from their bed multiple times. Action had not been taken to reduce this risk of them falling. Another person was recorded as being at risk of leaving the care home due to their confusion. Action had not been taken by the provider to reduce this risk. Both people were raised as concerns with the manager on the first inspection day and a lack of effective action had been taken when the inspector returned 2 days later.

Using medicines safely
● Topical creams were not stored safely. For example, people's prescribed skin creams were found to be in other people's rooms. This risks people receiving skin cream prescribed for someone else.
● People's prescribed creams were not recorded appropriately to show what they were for, or where they should be applied on the person. For example, one person had opened cream in their room. The prescription label showed it was prescribed 7 months ago. This cream had a shelf life of 7 days from when it was opened and so should then have been disposed of. Staff could not locate records on why this cream was needed and staff were unsure when it was last used.
● People's allergies to certain medicines were not consistently recorded across all their medicine documentation. This inconsistent allergy information had been sent from the pharmacy, but care home staff had not recognised the errors when receiving and checking this documentation. This increased the risk that unclear allergy information, about a person, would be available to the care staff and visiting professionals.
● Staff did not always record why 'as needed' prescribed medicines were given and whether the medicine had been effective. This increased the risks of medicine not being given for a suitable reason.

Preventing and controlling infection
● Equipment usage was not hygienic. For example, some people needed staff to use a hoist and sling to move them. Before the inspection, we had received a concern that staff were using the same sling for multiple people. The use of the same sling for multiple people was unhygienic. On the first day of the inspection, we raised concerns that slings did not have identifiable information to prevent their use for multiple people. However, when we returned 2 days later no action had been taken to add identifiable information to hoist slings. This left people at ongoing risk of infection.
● The service was unclean in several areas. We were not assured the provider was promoting safety through the layout and hygiene practices of the premises.
● We were particularly concerned about the 'sluice room', which was a closed room specifically designed for the disposal of human waste products. We observed that unclean urine bottles and bed pans were being stored in the sluice room and the shelf underneath this was dirty.
● The sluice room had no hand soap for staff to wash their hands. This is an infection control risk as staff need to be able to wash their hands effectively after handling human waste. When we returned 2 days later, the sluice room was unchanged and staff still did not have access to hand soap in that room.

People were not always kept safe from the risk of harm. This was a breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● 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.

Visiting in care homes
The providers approach to visitors, was in line with the government guidance in place at the time of the

inspection.

Staffing and recruitment

● Staff told us there were enough staff to support people. However, due to staff shortages staff would sometimes need to work longer hours, or more shifts, than they preferred. They told us this had impacted morale. However, staff felt confident the provider had recruited additional staff who would start work soon and that this morale issue would resolve.

● People told us there were enough staff to support them.

● Staff were safely recruited. For example, staff had disclosure and barring checks (DBS) to ensure they were of good character before starting work. Disclosure and Barring Service (DBS) checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.

Systems and processes to safeguard people from the risk of abuse

● People told us they felt safe from abuse.

● Staff had received training on how to recognise signs of abuse. Staff knew how to respond to any concerns and felt confident that the management team would act appropriately.

Inadequate

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 we rated this key question good. At this inspection the rating has changed to inadequate. This meant there were widespread and significant shortfalls in people's care, support and outcomes.

Ensuring consent to care and treatment in line with law and guidance
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 MCA. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, whether appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met.

- People did not always have the required mental capacity assessments in place. For example, staff explained that 1 person's mental health condition meant they would sometimes decline support to wash and dress. Staff would return later to offer support again. The person's ability to decline care had not been considered by the use of a mental capacity assessment. Staff did not have guidance on how to best support the person when they decided to decline care.
- Some people had additional monitoring in place, by the use of motion sensors. These sensors triggered staff to respond if the person forgot to press their call bell. People's understanding of this increased supervision had not always been assessed with the use of a mental capacity assessment.
- The manager advised there were no records of what Deprivation of Liberty safeguarding each person had in place. They were therefore unaware if there were any imposed conditions from these applications. We observed a referral made to the Deprivation of Liberty Safeguard team 2 months before, however due to the lack of record keeping the management team were unsure if this had been authorised. This poor oversight risks people's human rights not being upheld.

People's human rights were not always respected. This is because mental capacity assessments were not completed when required. Also, the management team were unaware whose human rights were impacted by a Deprivation of Liberty referral. This was a breach of regulation 11(1) of the Health and Social Care Act

2008 (Regulated Activities) Regulations 2014.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
●The provider did not use universally recognised risk assessments effectively. For example, 1 person's care records showed they had been slowly losing weight. Despite this continued weight loss, staff had stopped completing the malnutrition universal screening tool (MUST) with the person for the last 5 months. This meant the potentially increasing risk of weight loss, and action required to be taken to support the person, was not effectively considered by the provider.
● Government care guidance was not always followed. For example, some people 5 were prescribed highly flammable creams as a skin care medicine. Government guidance is that action should be taken to reduce the build-up of this cream to reduce the risk of setting fire on the person or their clothing etc. The provider did not have appropriate actions in place to manage this known ignition risk.

Staff support: induction, training, skills and experience
● Staff were not skilled to create food with an altered consistency (to prevent a person choking). The international dysphagia diet standardisation initiative (IDDSI) created a universal framework of common terminology to describe food textures and drink thickness (running on a numbered scale). Kitchen staff had not received training on how to prepare food in line with this current standard. Kitchen staff knowledge of this tool was poor when we asked.
● Care staff had not received training related to people's individual health conditions. For example, staff had not received training in epilepsy awareness, Parkinson's disease, motor neurone disease, or multiple sclerosis. This lack of training (and absence of information in care plans) increased the risk of staff not understanding people's conditions and how best to support them.
● Only 1 out of the 8 nurses employed at the care home had received training in falls prevention. None of the care staff had received falls prevention training. People at the service were known to be at risk of falls. The lack of training (and absence of guidance in care plans), increased the risk of staff not understanding how to most effectively reduce this risk.

Supporting people to eat and drink enough to maintain a balanced diet
● We saw that staff had poor quality guidance available to them on how to support 3 people's swallowing needs. This increased the risk of people not receiving food in an appropriate form to meet their needs. For example, in relation to one person, the guidance available to the kitchen staff simply stated their food should be provided to them in, 'small pieces'. However, the person had been prescribed a specific texture modified diet by an external health professional. This meant the kitchen staff had incomplete information available to them on how to prepare the person's food and the person was at an increased risk of significant harm caused by choking on food.
● Records were kept on how much people ate and drank. People spoke highly of the food provided and we saw people received enough food and drink.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● Some people had been prescribed altered diets due to their risk of choking on food. Other people did not require a modified diet. This specialist guidance was not clearly recorded and made available for staff to follow. For example, 7 months before the inspection a person had been prescribed a 'normal diet'. However, this wasn't clearly recorded in the person's care plan and we identified the person was still eating an altered diet. This was not in line with the external specialist guidance for that person.

● Visiting professional's advice was recorded, however this hadn't always been followed. One person had been losing weight and the GP had recommended weekly weighing. However, the person was still only receiving monthly weight checks. This meant the care staff were not monitoring the person in the way recommended by the GP.

Adapting service, design, decoration to meet people's needs

● The building needed some refurbishment. For example, some carpets were loose causing a potential trip hazard. However, the nominated individual showed us evidence that areas (like carpets) were planned for refurbishment.

● Some stair gates were used to limit people's access to the stairs. However, these were of a non-standard construction and had large gaps where people may get trapped. The safety of these stair gates had not been risk assessed to ensure they met the needs of people living at the home.

Inadequate

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 as good. At this inspection the rating has changed to inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

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

● Audits were not always carried out by the provider to ensure care was of good quality. For example, there were no audits for the safety of bed rails. This was a concern because the local authority raised the risk of unsafe bed rails 2 months before the inspection. A thorough audit by the provider's management team could have investigated and resolved this risk in a timely way.

● Where records were kept by staff, these were not always reliable. For example, cleaning records identified that the sluice room had been cleaned. We have described (in the Safe section of this report) that the sluice room was unclean. Therefore, these cleaning records were not accurate, and the provider's monitoring of the records was not effective.

● Staff were not always sure of roles of external healthcare professionals who visited the service. For example, staff told us they believed that a visiting nurse would complete checks on a piece of medical equipment used by a person. However, the staff weren't sure when this nurse last visited or how often the external nurse completed these checks. We expressed concern about this person potentially not receiving the required medical checks, so the staff phoned the nursing team to gather more information. They were informed that these checks were no longer needed. This lack of oversight meant staff were unsure of the person's current needs and who was completing the delegated nursing task.

● The provider did not have a clear list of which people were impacted by DoLs. This poor oversight meant the provider was not aware of whose human rights were impacted.

● We identified that the call bell system was not safe as it could not be heard in all areas of the care home (See Safe section of the report). The provider had not audited the call bell system. This failure to quality monitor the effectiveness of the call bell system would impact their ability to identify and mitigate the clear risks of this system being inaudible in some parts of the care home.

●Concerns were raised about the buzzer system on the first day of the inspection, when the inspector returned 2 days later no changes had occurred and the nominated individual advised it could take 3to 4 weeks to resolve. The inspector raised concerns that this was not a timely response and the nominated individual purchased additional buzzers to be placed in the corridor for staff to use. The inspector again expressed concern that these buzzers needed to be with the people to press for support themselves. Overall, the buzzer system at Oakdene Care Home was not effective at ensuring people had access to timely support. When this risk was raised, ineffective action was taken, leaving people at ongoing risk of a slow staff response.

Continuous learning and improving care; Working in partnership with others

● In November 2022, the Local Authority had completed an audit of the care home. After this audit, they explained their multiple quality concerns to the registered manager. There had been a failure to respond to Local Authority concerns. Due to this, the inspector raised these ongoing concerns on the first day of the inspection. When the inspector returned 2days later; action had either still not been taken or was not completed effectively.

● The local authority explained that the sluice room was unlocked. The sluice room was used for the disposal of human waste; it can therefore be unhygienic for non-trained people to enter. It can also contain hazards like chemical cleaning materials. On the first inspection day, the inspector explained that the room had not yet been locked and asked for urgent action to be taken. When they returned 2 days later the door had a coded lock added. However, the code to access this room was clearly written above this lock. This meant the room was still accessible to people.

● The local authority had also told the provider that their care plans were of poor quality. On the first day of the inspection, the inspector pointed out to the provider some specific people's care plans that presented the highest risk. When they returned these care plans had either not been amended, or the amendments were still of poor quality. One care plan remained a particular concern, so guidance was sent for the management team to consider. When the care plan was amended, it was found that it still did not follow this guidance document and staff still did not have sufficient guidance to provide safe care.

Systems had not been established to assess, monitor and mitigate risks to the health, safety and welfare of people using the service. This placed people at risk of harm. This was a breach of regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

● The provider did not always achieve good outcomes for people. This is because staff did not receive appropriate training and did not have clear guidance available to them to follow, to provide safe care to people.

● Staff told us they felt there was a positive culture at the service. They felt that staffing pressures had caused some low morale, but recent recruitment had improved staff wellbeing.

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

● People's care plans were not kept up to date, and we were not assured that their equality characteristics were always effectively considered.

● People told us that they felt able to feedback about the service. One person said, "I wouldn't hesitate if I had a complaint as (Nominated individual) would sort it out".

● People had confidence that the new manager would be effective at the service and was working hard to understand the service. One person said, "(Manager's name) is getting to know people and what goes on. I think they will do a good job."

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 provider is legally required to notify the CQC about events that happened at the service. These notifications had been sent as required.

● The provider had received a few complaints and these complaints had been responded to fully. The majority of people and relatives that we spoke with were happy with the care received.

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 11 HSCA RA Regulations 2014 Need for consent People's human rights were not always respected. This is because capacity assessments were not completed when required. Also, the management team were unaware whose human rights were impacted by a Deprivation of Liberty referral.

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 12 HSCA RA Regulations 2014 Safe care and treatment
Treatment of disease, disorder or injury	People were not always kept safe from the risk of harm. This

The enforcement action we took:

We have sent the provider a warning notice. This gives them a specified timescale to make the required improvements to the safety of the service.

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	Systems had not been established to assess, monitor and mitigate risks to the health, safety and welfare of people using the service. This placed people at risk of harm.

The enforcement action we took:

We have sent the provider a warning notice. This gives them a specified timescale to make the required improvements to the governance safety of the service.