Mrs Wendy Kwong

Oakapple 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 caring?	**Requires Improvement**
Is the service responsive?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

This inspection took place on 4 and 5 April 2018, and was carried out in response to concerns about the quality of care. The first day of our inspection visit was unannounced. We also undertook a visit to Oakapple Care Home on 24 May 2018 to assess whether measures had been put in place to mitigate some of the environmental risks. We then undertook a further check on 14 June 2018 to establish that action had been taken to reduce risks in relation to fire safety.

Oakapple Care Home was last inspected in September 2017 and was rated as Requires Improvement. We found one breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider had failed to implement effective systems to monitor, assess and improve the quality of care provided to people. Records relating to incidents and injuries did not provide accurate and complete information in relation to people's injuries and how they occurred. Following the last inspection, we asked the provider to complete an action plan to show what they would do and by when to improve the quality of care in relation to the breach, and we received this. On this inspection, we found that improvements had not been made to ensure the provider delivered care that met legislative requirements.

Oakapple Care Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Oakapple Care Home provides personal and nursing care for up to 10 people. At the time of our inspection, there were three people living there.

People were not kept safe. Risks associated with their health conditions were not consistently identified or reviewed. There was a risk that information available to staff about people's needs did not reflect their current needs. Risks associated with the environment were not reduced and mitigated.

People were not kept safe from risks arising from their health conditions. Action was not always taken to monitor and respond to changes in people's health needs. People were at risk because the provider could not assure themselves that staff were consistently monitoring people's health conditions and making timely referrals to health professionals.

There were sufficient staff to meet people's needs. However, staff did not always have training, support or checks on their care practices. There was a risk staff would not understand how to effectively support people's health and care needs.

The provider was not consistently working in accordance with the Mental Capacity Act 2005 (MCA), and people were at risk of not having their rights respected in this regard. People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible; the policies and systems in the service did not support this practice.

People were not consistently supported to eat and drink enough to maintain a balanced diet.

People were not supported to participate in designing or reviewing their care. People's needs and choices were not always identified and delivered in line with current legislation and evidence-based guidance. People did not always have care provided in a dignified or caring way.

The provider had not considered people's different communication needs in order to ensure people could participate in daily life in the service. For people who found verbal communication difficult, there was no evidence the provider had considered other ways of promoting effective communication. This meant people's views about their care were not heard and acted on, and the provider did not ensure people's autonomy and independence was enhanced.

The service was not managed well. There were failures to meet the fundamental standards in relation to safe care practices, managing risks, and staff training, planning and delivery of people's care, and following relevant legislation. Quality assurance processes to ensure people's safe care were not effective. The provider had not used feedback from external organisations to drive effective changes in the quality of care.

People's needs were met by the adaptation, design or decoration of Oakapple Care Home.

The service had a registered manager at the time of our inspection visit. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

We found five breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We also found one breach of the Care Quality Commission (Registration) Regulations 2009.

Full information about CQC's regulatory response to these concerns found during inspection is added to reports after any representations and appeals have been concluded.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms 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.

People were not protected from the risk of abuse or avoidable harm. People were not consistently kept safe from the risks associated with their health conditions. Medicines were not always managed safely.

Is the service effective?

Inadequate

The service was not effective.

The provider was not consistently working in accordance with the Mental Capacity Act 2005 (MCA). People were not consistently supported to eat and drink enough to maintain a balanced diet. People were not supported to maintain their health.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People did not always have care provided in a dignified or respectful way. The provider had not considered people's different communication needs in order to ensure people could express their needs and wishes effectively. People's confidentiality was respected.

Is the service responsive?

Inadequate

The service was not responsive.

People's care was not personalised to meet their individual needs. People were not supported to participate in designing or reviewing their care. People and relatives knew how to raise concerns or make complaints.

Is the service well-led?

Inadequate

The service was not well-led.

The provider had systems to monitor and review all aspects of the service, but these were ineffective. The provider had not always notified CQC of significant events as they are legally

required to do. Feedback from external organisations had not been acted on to improve the quality of care.

Oakapple Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 4 and 5 April 2018. The inspection visit was unannounced, and was carried out by one inspector. The inspection was prompted by concerns shared with us by the local authority in relation to the quality of care provided at Oakapple Care Home. These concerns related to staffing levels and skills, people's needs not being met, poor record keeping, and how infection prevention and control was being managed. This inspection examined those risks. The local authority also was investigating specific concerns about individual people's care under their safeguarding adults' responsibilities. We also undertook a visit to Oakapple Care Home on 24 May 2018 to assess whether measures had been put in place to mitigate some of the environmental risks. We then undertook a further check on 14 June 2018 to establish that action had been taken to reduce risks in relation to fire safety.

Before our inspection visit we reviewed the information we held about the service including notifications the provider sent us. A notification is information about important events which the service is required to send us by law. For example, notifications of serious injuries or allegations of abuse. We also sought the views of local authority and health commissioning teams. Commissioners are people who work to find appropriate care and support services which are paid for by the local authority or by a health clinical commissioning group.

On this occasion we did not ask the provider to send us a Provider Information Return (PIR). This is a form that asks the provider information about the service, what the service does well and improvements they plan to make. However, we offered the provider the opportunity to share information they felt relevant with us.

During the inspection we spoke with the three people who used the service, and one relative. Not all the people living at the service were fully able to express their views about care, so we also spent time discreetly observing how they were supported by staff during the inspection visit. We spoke with four care staff. We

also spoke with registered manager and the provider. We sought the views of four external health and social care staff. We looked at a range of records related to how the service was managed. These included three people's care records, including how their medicines were managed. We also looked at two staff recruitment and training files, and the provider's quality auditing system.

Inadequate

Is the service safe?

Our findings

Risks associated with people's health and social care needs were not consistently identified, assessed, reviewed or mitigated. For example, people were not supported to maintain healthy skin. Feedback to CQC from health professionals in February 2018 identified concerns about how the provider was assessing risks and taking action in relation to skin integrity. All three people at the service were at risk of their skin breaking down, and evidence showed the provider was not taking action to ensure risks were mitigated. One person had developed a pressure sore, and needed to be encouraged to stand hourly to relieve pressure areas. There was no specific guidance in the person's care records on what other actions staff needed to take to reduce risks. However, throughout the inspection visit we observed staff did not take action to support the person as recommended by healthcare professionals. We spoke with staff about this on the first day of our inspection visit, and they knew what action they needed to take. We observed the person was sitting on a chair that did not allow their feet to touch the ground, putting further pressure on their legs. During our inspection visit, the person was not supported by staff to stand hourly or elevate their legs. A second person was at risk of skin breakdown, and we identified there was no specific risk assessment of care plan in place for staff to follow. The provider had a monitoring tool in place to assist with evaluating risk, but this was not completed correctly or up to date. The provider had not ensured risks associated with people's skin needs were assessed and mitigated. This placed people at risk of further skin breakdown.

One person was supported to move using a hoist. There was no risk assessment for this. This meant there was no information to ensure staff knew how to mitigate risks when using the hoist to ensure the person's safety. The registered manager accepted this had not been done.

People were not supported to manage risks associated with their continence. This was an issue which had previously been identified by the local authority in March 2018. One person was unable to communicate their continence needs, and needed full support to manage this. Staff told us they checked the person's continence needs every two hours, and they were knowledgeable about the person's needs. However, there was no information in the person's care plan for staff to follow consistently. Records showed staff were not checking the person every two hours, and our observations during the inspection visit confirmed this. This put the person at risk of developing infections, and also at risk of further skin breakdown. This demonstrated the provider had not taken steps to ensure risks associated with people's continence needs were mitigated.

The provider's policy on identifying and assessing risks was focussed on building and equipment hazards, and did not support staff to address risks associated with people's health conditions. The registered manager confirmed they were responsible for ensuring risks associated with health conditions were identified, accessed and communicated to staff. They acknowledged they had not consistently ensured that this happened.

People were not kept safe from hazards associated with the building environment. Wardrobes in people's bedrooms were not secured to the walls. Risk associated with the use of bedrails had not been assessed and mitigated. This meant there was no information to ensure staff knew how to mitigate risks associated with bedrails. One person had sustained a minor injury associated with bedrail use on 13 October 2017. There

was no risk assessment in place, and their care plan had not been reviewed following the incident. We noted the record keeping associated with the incident was not contemporaneous. The registered manager accepted there was no evidence that any action to reduce risks had been taken as a result of the incident.

We found areas of exposed hot water piping and radiators that presented a risk if people came into contact with it. We visited again on 24 May 2018 and saw the provider had taken action after our initial inspection visit. However, they had not previously identified this as a risk. Fire safety checks were not consistently undertaken in accordance with the provider's policy. For example, the registered manager could not assure themselves that weekly fire alarm system checks were being carried out. Fire extinguishers were being used to prop two internal fire doors open. This meant there was a risk fire would spread more quickly in the building. The registered manager accepted that checks on the safety of the environment were not being done regularly, and that action was required to improve this. The provider had not consistently ensured risks associated with the service environment were identified and mitigated.

Plans for emergency situations were out of date. Staff knew what to do in the event of an emergency, but were unclear who would coordinate any emergency procedures. Information about what support people required in an emergency was not specific to their individual needs, and was out of date, as it had been written on 3 September 2013. There was no evidence that staff had undertaken any fire drills since 1 September 2016. The last check undertaken by the provider on fire doors and fire extinguishers was on 28 August 2017. The registered manager said the member of staff responsible for checks in relation to emergency planning had left. They confirmed no arrangements had been made to ensure risks associated with emergency situations were managed. There was a risk people would not be supported safely if there was an emergency.

Following our inspection visit, we asked Nottinghamshire & City of Nottingham Fire Authority to conduct a fire safety audit. This took place on 23 May 2018, and the provider was subsequently issued with a notice of fire safety deficiency under The Regulatory Reform (Fire Safety) Order 2005. We then undertook a further check on 14 June 2018 to establish that action had been taken to reduce risks in relation to fire safety.

When things went wrong, lessons were not learnt to improve care and ensure people's safety. Action was not taken following incidents to ensure people were protected from the risk of further harm. For example, one person had fallen in their bedroom on 13 October 2017, and the incident record identified they had been close to hot pipes, risking burns. The record stated action had been taken to cover the pipes, but staff told us and we saw that no action had been taken to mitigate the risk. The registered manager confirmed that, as part of an action plan to address concerns, they were now reviewing incidents. Prior to February 2018, accidents and incidents were not consistently reviewed or monitored to identify trends and to prevent reoccurrences. This meant risks arising from accidents were not always identified in order to reduce the risk of future harm to people.

Medicines were not always managed safely. We identified gaps in recording medicines, and there were no checks or audits in place to enable this to be identified and investigated. The registered manager told us they felt staff were giving medicines correctly, and this was a recording issue. Medicine storage temperatures were not being monitored, despite the provider having a system in place to prompt this daily. This meant there was a risk medicines would be ineffective. The storage facility for medicines was not kept clean, and bottles with liquid medicines were sticky. Protocols for PRN (as required) medicines were not consistently available for staff to follow. One person needed staff to monitor for signs of pain, as they could not verbally communicate this to receive their PRN medicine. Staff were unclear on what non-verbal signs to look for, and there was no information on this in the person's care records. Staff did not have guidance on when they should give PRN medicines to people, placing them at risk of not receiving medicines when they were

needed. Another person was prescribed creams for their skin. There were no directions for staff on where cream should go. Multiple bottles of one cream were opened, with no record of how long they had been open for. There was a risk the prescribed cream was not fit to be applied and would not be effective. The registered manager acknowledged the issues we identified and said they would take action. There was no system in place for the provider or registered manager to ensure people's medicines were stored, documented, administered and disposed of in accordance with current guidance and legislation.

These were breaches of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were not always protected from the risk of abuse or unsafe care at Oakapple Care Home. Staff knew how to identify people at risk of abuse or suspected abuse, and said they would recognise and report concerns. They also knew how to contact the local authority or the Care Quality Commission (CQC) with concerns if this was needed. Staff received training in safeguarding people from the risk of avoidable harm and this was supported by training records. The provider had policies on safeguarding people from the risk of abuse. However, we witnessed care practices that were unsafe, and staff did not recognise this. For example, staff continued attempting to support one person with their meal, who was clearly communicating they did not want this to happen. The person's care plan stated that if this happened, staff should stop, and try again later. This meant staff knowledge and training was not put into practice, and there was a risk that abuse would not be recognised or reported. Local authority staff involved in investigating safeguarding allegations expressed concerns that the provider did not always undertake actions identified as necessary to ensure safe care. The processes and practices in place did not consistently protect people from the risk of abuse or neglectful care.

The provider did not always undertake pre-employment checks, to help ensure prospective staff were suitable to care for people living at the service. This included obtaining employment and character references and disclosure and barring service (DBS) checks. A DBS check helps employers to see if a person is safe to work with vulnerable people. Evidence provided by the local authority identified that one staff member did not have a DBS check. This staff member had confirmed with us on the inspection visit that they undertook care tasks at night if needed, and records supported this. This placed people at risk as the provider had not checked whether all staff were of good character and were fit to carry out their work.

People were not consistently kept safe from the risks associated with infection. A relative described the service as, "Not the cleanest." The clinical commissioning group (CCG) carried out an unannounced Infection Prevention and Control audit on 5 October 2017. This identified a range of issues, and the CCG gave the provider actions to take to improve infection control. The provider had taken action, but we identified areas where the prevention and control of infection still required improvement. For example, we found items of bedroom furniture where fabrics were stained or torn. A bedroom windowsill had flaking paint. This meant staff would not been able to effectively clean these. Throughout our inspection, we saw there were ants on the floor and dining table in the conservatory. We spoke with the registered manager about this, but they did not indicate what action they planned to take to ensure this was dealt with. They confirmed there had been inconsistent auditing and checks on the cleanliness of the service.

Relatives felt there were enough staff to support people. Staff shared this view, and our observations during the inspection visit confirmed there were sufficient staff to meet people's needs.

Inadequate

Is the service effective?

Our findings

The provider had not consistently ensured that people received care from staff who had been given training and support to enable them to meet people's assessed needs. Staff told us they had an induction and training when they started work. Records we viewed were incomplete, and the registered manager could not consistently evidence how they supported and assessed the care skills of new staff. For example, one staff member's training records had evidence of a one day induction, but the provider's policy stated staff had an induction over 12 weeks with a range of training and skills checks. This was not evidenced from the records we viewed, and the registered manager was unable to confirm if the staff member had received the full induction in accordance with the provider's policy.

In response to concerns about staff training and skills raised by the local authority, CQC asked the provider to submit evidence detailing how this was being addressed. An action plan was returned by the registered manager. This included assurance that staff were undertaking external training qualifications, and would be having checks on their care skills by the provider. Staff told us and we saw evidence to show they were now undertaking training. For example, staff attended training on 5 April 2018 in relation to safe moving and handling. The registered manager told us they carried out regular spot checks on staff's care skills, but that they did not always record this. For example, another staff member had not had any checks of their personal care skills since 20 November 2017. Staff told us the registered manager mostly worked on the night shift, and the registered manager confirmed this, which limited their time to work alongside staff during the day. This meant there was insufficient evidence that staff were being given support and feedback to enable them to improve their care practices. We asked the registered manager to provide us with a copy of the staff training matrix on 5 April 2018, but this was not given to us. This meant we were unable to verify the training staff had undertaken. The provider was unable to assure themselves that they had provided staff with training to meet people's needs.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were not consistently supported to eat and drink enough to maintain a balanced diet. All three people living at Oakapple Care Home needed assistance to eat and drink. For example, one person needed staff to remain with them to ensure they could locate their food and drink. Support was also needed to reduce the risk of the person choking. The person told staff they could not see their food or drink repeatedly, but there were five occasions where the person was left unsupported. This was an issue which was also identified by local authority staff during a visit in March 2018. Care records were clear that staff needed to supervise the person with food and drinks. This placed the person at risk of having insufficient food and drinks, and at risk of choking.

Records relating to people's food and drinks were not consistently completed, which made it hard for staff to assess whether people's diet and fluids were sufficient or well-balanced.

People were not consistently supported to maintain their health. For example, one person needed support

to reposition themselves when seated to prevent skin deterioration. There was no information in their care plan for staff to follow, and staff did not know how often the person needed support to reposition. This lack of information meant they were at risk of not receiving appropriate support from staff in a timely manner. Records showed there were occasions when the person sat for between six and eight hours, for example, on 11, 12 and 13 March 2018. Records to show how often staff supported the person to change position were not always completed. The registered manager could not tell us if staff supported the person more frequently. Staff and the provider were not following professional advice, and this placed people at risk of further skin breakdown.

Another person was at risk when swallowing fluids, and had specific health professional guidance for staff to follow. This included clear instructions for staff to supervise the person when eating and drinking, and to record what the person ate and drank. Staff confirmed this was the case. Although the person's food and drinks were documented, this information was not reviewed or evaluated in order for their diet to be monitored effectively. We saw during the inspection visit there were times when the person was given food and drink, and left unsupervised. The provider was not ensuring staff followed professional health advice, and the person was at risk of choking, and at risk of not receiving a diet to meet their needs. People were at risk because the provider could not assure themselves staff were consistently monitoring people's health conditions. The provider could not assure themselves that people's health needs were met.

These were breaches of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider was not consistently working in accordance with the Mental Capacity Act 2005 (MCA), and people were at risk of not having their rights respected in this regard. The 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 Act 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 be as least restrictive as possible.

People's consent to care was sought for most daily personal care activities. Relatives confirmed that staff sought permission before offering care. However, where people lacked capacity to consent to aspects of their care, the MCA was not consistently followed. Assessments of people's capacity to consent to specific care activities were not always completed. This had been identified by the local authority in February 2018; they had asked the registered manager to ensure this was done. However, our inspection visit found there was evidence that people's capacity to consent to their care was not consistently assessed where this was needed. Staff understood the principles of the MCA, including how to support people to make their own decisions. However, the provider could not consistently demonstrate how people and their relatives' views were sought as part of best interest decision making in relation to their personal care. This meant people were at risk of not having their rights upheld in relation to consent to care.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. The provider had sought authorisations appropriately for people. Evidence from the care records and registered manager showed people who were subject to DoLS did not have their care reviewed regularly to ensure that restrictions continued to be proportionate and in their best interests. This meant people were at risk of not having their rights upheld in relation to restrictive care practices. People deprived of their liberty had a Relevant Persons Representative (RPR). RPRs ensure people have

support to exercise their rights in relation to the MCA and DoLS. The provider was not consistently working in accordance with the MCA, and people were not always protected from care practices that were overly restrictive and unlawful.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's needs and choices were not always identified and delivered in line with current legislation and evidence-based guidance. For example, the National Institute for Health and Care Excellence (NICE) guidance on "Pressure ulcers: prevention and management", Clinical guideline (CG179), was not being followed in relation to ensuring people were repositioned in accordance with their assessed needs. NICE provides national guidance and advice to improve health and social care. We found staff were using an out of date copy of the British National Formulary (BNF). BNF publications reflect current best practice as well as legal and professional guidelines relating to the uses of medicines. The provider had not ensured there was up to date medicines guidance available to staff. There was a risk people received care that did not meet with current legislation.

Assessment of people's needs in relation to protected characteristics under the Equality Act were considered in people's care plans. For example, people's needs in relation to any disability were identified. This helped to ensure people did not experience any discrimination.

The provider did not consistently ensure staff worked effectively with other organisations to deliver effective care, support and treatment. For example, one person needed thickened fluids to reduce the risk of choking. They had been reluctant to drink thickened fluids, but staff did not alert external health professionals to enable further assessment to take place in a timely way. The registered manager took action to remedy this, and also to reduce the risk of the incident occurring again.

People's needs were met by the adaptation, design or decoration of Oakapple Care Home. People's living space, bedroom and bathroom facilities were all on the ground floor to enable full access for anyone with mobility needs. People were supported to make choices about decorating their personal space, and their bedrooms were personalised. People had access to a garden area, and this was designed to give easy access to people using walking aids or wheelchairs. This meant the provider had taken steps to ensure the environment was suitable for people's needs.

Requires Improvement

Is the service caring?

Our findings

People were not consistently treated with kindness and respect. For example, one person was clearly communicating they did not want to drink any more. The staff member supporting them to drink continued to hold the cup to their mouth and did not respond to the person's non-verbal communication. The person's care plan was clear staff should stop and offer the drink again later. Staff also used language (in verbal and written communication) that was not respectful. For example, we heard staff saying, "Are you going to commode them?" when discussing what support people needed to use the toilet. We spoke with the registered manager about this, and they confirmed they would take action to ensure staff demonstrated respect throughout their work.

People were not given information about their care plans or reviews of care in ways that were meaningful to them; for example, in easy read or pictorial formats. The provider had considered people's different communication needs to ensure they could participate in daily life, but did not ensure staff met those needs consistently. For example, one person had both visual and hearing impairments. Staff told us they needed to ensure they were positioned close to the person, and had their attention to ensure they were heard. Records confirmed staff needed to speak slowly and clearly, and ensure good lighting to enhance the person's vision. We saw staff did not consistently follow this guidance, and we needed to prompt staff to ensure the person was seated in a well-lit area. When the person was sitting in a well-lit area, we noticed they were less withdrawn and spoke more. Staff agreed this was the case, and said the person often seemed more alert and talkative sitting there. However, our observations and care records evidenced the person usually sat in an area which was not as well-lit. There was a risk people's own communication needs were not understood, and therefore their ability to respond and express themselves would be affected.

People were not consistently supported to participate in the design or review of their care plans. A relative and staff told us, and records showed care plans were reviewed with relatives where this was appropriate. We spoke with the registered manager, who was responsible for reviewing care. They confirmed there was no meaningful involvement for people, but that they planned to improve this for future reviews.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

However, we saw staff take time to sit with people, offering reassurance and chatting. One relative said their family member enjoyed the company and attention staff provided. However, they commented that staff needed to make sure their communication approaches were suitable for the person. Staff had sufficient time to spend with people who appeared anxious or agitated. For example, one person appeared unsettled, and staff had time to support them in a calm and unobtrusive manner. This enabled the person to get the reassurance they were requesting, and they appeared happier. We also saw staff speak with people respectfully, for example, always checking that support being offered was what people wanted.

Staff respected people's right to confidentiality, but knew when it was appropriate to share information about risk or concerns. Records relating to people's care were stored securely. People's confidentiality was

respected.

People were supported to spend private time with their friends and family if they wished. There were two lounges and a conservatory, as well as private bedrooms to give people and their relatives a choice of where they wished to spend time together. Relatives told us they were able to visit whenever people wished, and there were no restrictions on visiting times. This showed people's right to private and family lives were respected.

Inadequate

Is the service responsive?

Our findings

People's care was not personalised to meet their individual needs. There were insufficient processes in place to ensure that staff had access to adequately detailed care plans. This meant staff did not have sufficient or consistent guidance to inform support. For example, one person had a diagnosis of epilepsy and type 2 diabetes. There was no information in their care plan about how these conditions affected them, how staff should support them to manage these conditions. Another person was at risk of damaging their hand through a repetitive behaviour. Staff told and showed us how they supported the person with this behaviour during the day, but were unclear how this was managed at night. There was no risk assessment or care plan in place to inform staff how to consistently support the person with this behaviour and reduce the risk of damage to their hand. There was no evidence that staff were consistently recording any bruising, or that the person's needs were reviewed to help ensure their needs were met. This failure to ensure all staff had access to clear guidance about people's needs to provide individualised care.

Staff told us, and we saw people were supported to express their views and wishes about their daily lives, but this was not consistently evidenced in care records. For people who were less able to communicate verbally, there was no evidence how staff sought their views, wishes and aspirations. For people who found verbal communication difficult, there was no evidence the provider had considered other ways of promoting effective communication. This meant there was a risk people's views about their care were not heard and acted on, and the provider did not ensure people's autonomy and independence was enhanced.

The provider had not taken steps to meet the Accessible Information Standard (AIS). The aim of the AIS is to make sure that people who have a disability, impairment or sensory loss get information that they can access and understand, and any communication support that they need.

People were not supported to participate in activities that were meaningful to them. There was no evidence in the service of any planned activities such as crafts and activities of daily living that reflected people's interests or hobbies. There was no evidence that the provider had worked with people or relatives to identify and offer accessible activities. Staff told us, and we saw they would occasionally offer activities they thought people would like. For example, one person enjoyed having their nails cleaned and manicured on the second day of our inspection visit. However, this activity was not part of any planned approach with the person to ensure they had regular opportunities to take part in activities of their choice.

We observed some, but not all staff took opportunities to engage people in interesting conversations to stimulate them. We observed that for some people they spent the morning passively watching television or falling asleep. We noted people were supported to spend time on their beds in the afternoon during our inspection visit. Staff were unclear why this was necessary, and there was no information to demonstrate that this was an assessed need for people. People experienced little support to maintain interests and hobbies, and were not encouraged to maintain aspects of independence.

There were no formal menu plans as there were only three people living at the service. Staff were directed to prepare food in accordance with people's needs and preferences, and the registered manager confirmed

this. There was little information available to staff about people's individual food preferences, and no evidence to support people's involvement in planning their meals.

People and, where appropriate, their relatives were not involved in discussions about their wishes regarding care towards the end of their lives. This should be where people would like to be at the end of their lives, whether they would like to receive medical treatment if they became unwell, and in what circumstances. There was no evidence to demonstrate the provider had tried to ensure end of life care plans were in place. This meant people were not supported to express their views about their future care towards the end of their lives, and staff would not know how to support people and their relatives in the way they wanted.

These were breaches of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

A relative felt able to raise concerns and knew how to make a complaint, and was aware the provider had a complaints procedure to support this. There was no information around the service about how to make a complaint. There were no records of any complaints made to the service. The provider's policy on complaints did not have up to date information on where people and relatives could take complaints if they were not satisfied with the provider response. The registered manager told us no complaints had been received, so were unable to assess whether complaints were managed in accordance with the provider's policy.

Inadequate

Is the service well-led?

Our findings

At our previous inspection in September 2017, we found a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider had failed to implement effective systems to monitor, assess and improve the quality of care provided to people. Records relating to incidents and injuries did not provide accurate and complete information in relation to people's injuries and how they occurred. Following the last inspection, we asked the provider to complete an action plan to show what they would do and by when to improve the quality of care in relation to the breach, and we received this. On this inspection, we found the provider had failed to improve their systems to monitor, assess and improve the quality of care provided to people.

The service was not well-led. During this inspection we identified shortfalls across all of the key questions we ask about services. This included failures in safe care practices, care that was not person-centred, and concerns about how risks associated with people's health needs were managed.

The provider did not have a clear vision or credible strategy to deliver high-quality care and support. Although staff understood their roles and responsibilities, the provider was unable to demonstrate staff were supported to provide care that was in accordance with the provider's statement of purpose. A statement of purpose is a legally required document that includes information about a provider's service, including the provider's aims, objectives and values in providing the service. Staff did not consistently demonstrate that the training, skills and values the provider required were put into practice.

The provider did not ensure their systems and practices were used to consistently deliver person centred care. We identified aspects of people's care that was neither responsive to their individual needs or caring. Any checks carried out by the registered manager or provider had failed to identify this.

Systems and processes in place did not identify learning from incidents and mitigate any future risks to people. The provider could not demonstrate training gave staff the skills and competence needed to support people safely and effectively. There was also little evidence that staff understanding or competency was assessed following their induction or training. People were at risk of being supported by staff who did not have the support, supervision, training or skills to meet their needs.

Records relating to people's health and social care needs were not kept up to date or consistently completed. There were no audits carried out by the registered manager or provider to identify records were not accurate or contemporaneous, and no action had been taken to rectify this.

Systems and processes in place to monitor and review the quality of the service were not effective. Checks and audits of the quality of the service were not undertaken to ensure personal care was provided safely. For example, there were no regular checks to ensure risks to people were identified and mitigated. Medicines were not always managed safely, and there were no checks in place to ensure action was taken quickly to rectify this. There was no coherent system to review people's care with them to ensure it met their individual needs, and met with legal requirements. The provider responded to concerns raised by external health and

social care professionals, but this was reactive. The systems in place were not used by the registered manager or provider to proactively identify issues quickly and take action. The registered manager was aware of the issues we identified on our inspection visit, but they and the provider had not taken sufficient steps to rectify this.

The provider had a range of policies and procedures in place to support the registered manager and staff in delivering care to people. Many of the policies we viewed did not reflect current legislation or regulatory requirements. For example, the policy on infection prevention and control did not reference up to date legislation and code of practice. The provider's policy on assessing and mitigating risks associated with care provision did not provide staff with guidance on how to manage risks associated with people's healthcare needs. The provider had not ensured there was up to date or accurate guidance on what was expected of staff when providing personal care. This put people at risk of receiving care that was unsafe and did not meet legislative requirements.

Feedback from external organisations had not been acted on to improve the quality of care for people living at Oakapple Care Home. For example, health professionals undertook a visit in response to concerns raised about skin care. A number of recommendations were made to improve care, but we found action was not always being taken to reduce risks relating to people's skin care. The local authority's quality monitoring visit on 11 August 2017 had also identified a range of areas where care needed to improve. For example, ensuring people and relatives were fully involved in the care planning process and reviewing of plans of care, and ensuring care plans were fully person centred. An external infection prevention and control audit was carried out on 6 November 2017 which identified action the provider needed to take to manage the risk of preventable infections. Despite feedback given to the provider from a range of external organisations in relation to the quality of care, the provider had not taken sufficient action to ensure people's care was safe.

Following our inspection visit, the local authority carried out a quality monitoring visit on 25 April 2018. They identified further issues with care records not being updated to reflect people's current health needs. They also observed staff administering medicine to one person where good hygiene practices were not followed. The provider was not using feedback to improve the quality of care for people at the service.

There were no systems in place to gather the views of people, relatives or staff about how the service was run, and how improvements could be made and sustained.

These were continued breaches of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had not always notified CQC of significant events as they are legally required to do. For example, the local authority made CQC aware of an incident on 30 January 2018 in relation to how staff supported a person to mobilise. The local authority made CQC aware of a further safeguarding investigation in relation to another person's care on 19 February 2018. The registered manager confirmed they had not notified CQC as they are required to do. This meant the provider was not informing CQC of significant events that occurred in the service which would have assisted us to monitor the quality of care. We spoke with the registered manager about this, and received assurance that notifications would be made in future.

This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

The provider was not displaying their ratings from the previous inspection as required by the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We spoke with the registered manager about this, but by the end of the second day of the inspection visit, action had not been taken to rectify this.

This was a breach of Regulation 20A of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service had a registered manager at the time of our inspection visit. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The registered manager understood their responsibilities, but did not consistently ensure they demonstrated this in their managerial duties.

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 18 Registration Regulations 2009 Notifications of other incidents The provider had not always notified CQC of significant events as they are legally required to do. This meant the provider was not informing CQC of significant events that occurred in the service which would have assisted us to monitor the quality of care.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care People were not consistently treated with kindness and respect. People were not given information about their care plans or reviews of care in ways that were meaningful to them. The provider had considered people's different communication needs to ensure they could participate in daily life, but did not ensure staff met those needs consistently. There was a risk people's own communication needs were not understood, and therefore their ability to respond and express themselves would be affected. People were not consistently supported to participate in the design or review of their care, or to participate in activities that were meaningful to them.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Where people lacked capacity to consent to aspects of their care, the MCA was not

consistently followed. Assessments of people's capacity to consent to specific care activities were not always completed. The provider could not consistently demonstrate how people and their relatives' views were sought as part of best interest decision making in relation to their personal care. This meant people were at risk of not having their rights upheld in relation to consent to care. People who were subject to DoLS did not have their care reviewed regularly to ensure that restrictions continued to be proportionate, in their best interests and less restrictive.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 20A HSCA RA Regulations 2014 Requirement as to display of performance assessments The provider was not displaying their ratings from the previous inspection as required by the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We spoke with the registered manager about this, but by the end of the second day of the inspection visit, action had not been taken to rectify this.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had not consistently ensured that people received care from staff who had been given training and support to enable them to meet people's assessed needs. The provider could not consistently evidence how they supported and assessed the care skills of new staff. There was insufficient evidence that staff were being given support and feedback to enable them to improve their care practices. The provider was unable to assure themselves that they had provided staff with training to meet people's needs.

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 Risks associated with people's health and social care needs were not consistently identified, assessed, reviewed or mitigated. People were not kept safe from hazards associated with the building environment. No arrangements had been made to ensure risks associated with emergency situations were managed. When things went wrong, lessons were not learnt to improve care and ensure people's safety. Action was not taken following incidents to ensure people were protected from the risk of further harm. Medicines were not always managed safely. There was no system in place for the provider or registered manager to ensure people's medicines were stored, documented, administered and disposed of in accordance with current guidance and legislation. People were not consistently supported to eat and drink enough to maintain a balanced diet. People were not consistently supported to maintain their health. The provider could not assure themselves that people's health needs were met.

The enforcement action we took:

Cancel registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not have a clear vision or credible strategy to deliver high-quality care and support. The provider did not ensure their systems and practices were used to consistently deliver person centred care. Systems and processes in place did not identify learning from incidents and mitigate any future risks to people. The provider could not

demonstrate training gave staff the skills and competence needed to support people safely and effectively. Records relating to people's health and social care needs were not kept up to date or consistently completed. Systems and processes in place to monitor and review the quality of the service were not effective. There were no regular checks to ensure risks to people were identified and mitigated. There was no coherent system to review people's care with them to ensure it met their individual needs, and met with legal requirements. Systems in place were not used by the registered manager or provider to proactively identify issues quickly and take action. The provider had not ensured there was up to date or accurate guidance on what was expected of staff when providing personal care. Feedback from external organisations had not been acted on to improve the quality of care for people. There were no systems in place to gather the views of people, relatives or staff about how the service was run, and how improvements could be made and sustained.

The enforcement action we took:

Cancel registration.