Florence Care Homes Limited

The Oaks Residential Care Home

Inspection report

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31 January 2018

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This was an unannounced and focused inspection carried out on 25 and 31 January 2018

The Oaks is a residential care home that provides personal care for up to 30 older people, including people living with dementia. On the day of our inspection there were 17 people using the service.

We carried out an unannounced comprehensive inspection of The Oaks Residential Home on 24 and 31 August and 26 September 2017, and we found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The service was given an overall judgement rating of 'inadequate' and is therefore in Special Measures.

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

The service had no registered manager in post. However, a new manager who intended to apply for registration had started work at the service the day before our inspection. 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.

Following our inspection in August and September 2017, we took immediate enforcement action to restrict admissions to the service. We placed conditions on the provider's registration requiring them to demonstrate that the numbers, skill mix and competency of all staff was appropriate for the care and support needs of people living at the service. This inspection was undertaken within the six months timescale because we received further information of concern from the local authority and whistle blowers, which related to poor staffing levels and poor care. Because of this, we wanted to check that the enforcement action, which had been taken, was resulting in improvement.

This inspection focused on the areas of safe and well-led. We found that sufficient improvements had not been made since our last inspection in August and September 2017 and the provider was continuing to fail to meet the requirements of the regulations, commonly referred to as The Fundamental Standards of Quality and Safety.

There were insufficient numbers of staff on duty to meet people's care and support needs. People's care had not been co-ordinated or managed to ensure their specific needs were being met safely. People were not protected from the unsafe management of medicines.

Robust and sustainable audit and monitoring systems were not in place to ensure that the quality and safety of care was consistently assessed, monitored and improved. Failures in the service continued to be widespread and demonstrated the provider's inability to make and sustain improvements.

The Commission is currently considering its enforcement powers. This includes taking action in line with our enforcement procedures to begin the process of cancelling the provider's registration.

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.

There were insufficient numbers of staff on duty to meet people's care and support needs.

People's care had not been co-ordinated or managed to ensure their specific needs were being met safely.

People were not protected from the unsafe management of medicines.

Is the service well-led?

Inadequate

The service was not well-led.

Robust and sustainable audit and monitoring systems were not in place to ensure that the quality and safety of care was consistently assessed, monitored and improved.

Failures in the service continued to be widespread and demonstrated the provider's inability to make and sustain improvements.

The Oaks Residential 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.

We undertook this unannounced focused inspection of The Oaks Residential Home on 25 and 31 January 2018. This inspection was carried out to check that improvements to meet legal requirements had been made by the provider following our comprehensive inspection on 24 and 31 August and 26 September 2017. The inspection was carried out by two inspectors and a specialist advisor with knowledge and experience of nursing and residential care.

During this inspection we spoke with two people using the service. We spoke with the manager and the nominated individual. The nominated individual is a person nominated by the provider to supervise the management of the regulated activity provided. We also spoke with five members of staff and observed the interactions between staff and people.

To help us assess how people's care and support needs were being met we reviewed ten people's care records and other information, for example their risk assessments and medicines records.

Inadequate

Is the service safe?

Our findings

At our last inspection in August and September 2017 and our previous inspection in June 2016 we found that people were not protected against the risk of unsafe care, particularly in relation to insufficient staffing levels. There had not been enough staff to provide the right level of care and staff were not deployed in a way that ensured people's safety. Following our inspection in September 2017 we took immediate enforcement action to restrict admissions in to the service. We placed conditions on the provider's registration requiring them to demonstrate that the numbers, skill mix and competency of all staff was appropriate for the care and support needs of people living at the service.

At this inspection we found , although numbers of staff rostered to work each shift had increased, the actual number of staff on duty did not always correspond with the number recorded on the roster. On the first day of our inspection we found that the number of staff on duty did not match the roster. In addition to this, staff on duty were not effectively deployed, as the senior care staff member did not have the time to lead the shift or allocate tasks.

The shortage of staff meant the morning medicines round was delayed. The senior member of care staff responsible told us, "We are short of staff today which meant that I started the medicine round an hour late". We observed that the medicine round did not finished until 11.15am which meant that an appropriate time was not allowed between doses of some medicines, putting people at risk of receiving an overdose of medicines.

The rosters for the period 3 to 21 January 2018 showed that there had been other occasions where the service has been short staffed and levels did not match what was recorded on the rota. There had been one occasion where only two out of three night staff were on shift and another occasion where two out of four care staff were on shift. Our observations told us that even when fully staffed according to the rota, staffing levels were insufficient to meet service user's' needs. When staffing levels dropped even further service users were exposed to significant risk of harm due to severely insufficient numbers of staff being available to support them.

There were 17 people living at The Oaks, 13 of whom required the assistance of two care staff in order to mobilise and/or receive personal care. Three people had been assessed as requiring the assistance of two care staff but were also identified as frequently attempting to stand and walk unaided. On the first day of inspection, there were numerous times throughout the day when the communal areas were left unattended by staff. On one occasion, a person was seen to attempt to stand and inspectors had to alert a member of staff as this person was known to be at risk of falls if left unattended. Another person with swallowing difficulties was seen to cough and start to choke whilst eating in the dining area. No staff were present until a senior staff member noticed from the corridor that the person had spat out their food on to the table. They came to assist for a short while but were needed elsewhere and had to leave the person alone again. This put the person at increased risk of choking as well as leaving them without emotional support following the incident.

Despite assurances from the provider following our last inspection that a member of staff would be present in the communal areas at all times during the day, we found this was not the case. The falls log showed that there had been a number of unwitnessed falls in the communal areas when staff had not been present. Had a staff member been present prior to these incidents, they could have potentially supported the person to prevent them from falling. With no supervision, people had continued to be put at risk of harm.

Staff fed back that the high number of people requiring the assistance of two staff meant that even when fully staffed according to the rota, it was not possible for one of them to be present in the communal areas all of the time. In the afternoon, the number of care staff decreased meaning it was only possible for one person requiring double assistance to be supported at any one time between the hours of 2.00pm and 9.00pm unless a senior care staff member also provided assistance, which meant they were unable to lead the shift.

Following the first day of inspection the provider assured us a schedule had been prepared which showed which member of staff should be present in the communal areas between the hours of 8am and 7pm. When we visited again on 31 January 2018 we found that no such schedule was available. The manager, senior care staff member and other care staff members on duty said this had not yet been formally established. They were attempting to make sure this area was supervised but this was being arranged by the senior care staff member on each shift. We observed that a member of care staff was present in the communal area but this was a member of staff who had been identified as having received no training. They confirmed they had not yet received moving and handling training but were due to undertake this later that week. In the meantime people remained at risk as the member of staff did not have the knowledge required to take appropriate action should assistance be required.

Staff were not aware of people's whereabouts in order to keep them safe. They were unable to effectively monitor the communal areas due to people's high physical and emotional support needs. We observed the manager providing support to a person to walk along the corridor. This person had been assessed as requiring constant supervision during the day due to their high risk of falls. At the same time, another person moving along the corridor required immediate assistance. The manager had no other option but to accept our inspectors offer to continue to observe the other person as they walked into the lounge. As they walked into the lounge a wheelchair was obstructing their path but this went unnoticed by the member of staff observing the area at the time, as they were assisting another person with their meal. A visitor to the service assisted by moving the wheelchair out of the way. Had the inspector not been present the person would have been unattended as they walked into the lounge putting them at risk of a further fall and significant injury.

In addition to this, poor practice and a poor culture in the service meant that staff were not performing the tasks assigned to them in order to keep people safe. We observed a member of staff responsible for monitoring the communal areas using their mobile phone when they were supposed to be watching to ensure people were not at risk.

Additional tasks allocated to staff such as responsibilities for food handling or assisting people with baths or showers had not been considered when calculating the number of staff required. Bath and shower records showed that on the week commencing 15 January 2018 only two people had received a shower and two a bed bath. On the week of 22 January 2018 only two people had received a shower according to the records. Time had also not been factored in to allow staff to spend quality time engaging people in meaningful activities. This meant staff were not supported to effectively provide the right care and reduce risks associated with escalating anxieties.

On 31 January 2018 we were informed by the manager that the provider had agreed to provide an additional member of agency staff for both the morning and afternoon shift. This would start with immediate effect the next day. Whilst this mitigated some of the immediate risk in terms of the numbers of staff on duty, we remain concerned regarding levels of staff competency and ability to guide the agency staff to ensure service users were kept safe and that all of their support needs were met.

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

People's care was still not co-ordinated or managed to ensure their specific needs were being met safely. Individual risk assessments were not effective and effective care planning strategies were not in place in relation to people's physical and mental health needs. Staff did not have sufficient guidance on the support people required to meet these needs and keep them consistently safe.

There was no system in place to ensure staff knew and understood the bespoke moving and handling needs of people or the correct equipment and aids to use. Moving and handling assessments for people requiring the use of the hoist did not state the type or size of sling to be used, according to their support needs, size and weight. We observed the same sling being used for all people being assisted to move using the hoist in the lounge area. This put people at serious risk of personal injury as they could fall out of a sling that was not the correct size. In addition to this, people were exposed to the risk of the spread of infection through use of the same sling.

The care plan for one person stated that a handling belt was to be used when supporting them to stand but staff told us that this had not been communicated to them. One member of staff told us, "I have not been told about the handling belt and I didn't get to read the care plan. The nurse came out yesterday and said that [person] should have been assessed before they came out of hospital. We were not told anything [about the handling belt] at handover or the start of the shift". We observed two members of care staff assist this person to stand without using a handling belt. When we spoke with both members of staff separately later that day they told us that they were unaware this had been provided and should be used.

This person was known to be at high risk of falls and in the past year they had fallen on 10 occasions. However, records of falls were inconsistent and there had been no analysis of these falls to identify common themes or to establish what steps could be taken to reduce the risk of future falls. A referral to the falls prevention team had been made but there was no evidence of any visit or recommendations made by them to guide staff as to how they could help to keep this person safe.

Care plans contained conflicting and inconsistent information regarding the level of support people required to mobilise. For example, the care plan for one person stated that they had a history of falls and that they would, at times, mobilise without their rollator frame putting them at risk of a further fall. Despite this, their falls risk assessment assessed them to be at low risk of falls. Without accurate details about the level of support each person required staff did not have the information they needed to know how to effectively and safely support people. This meant people might not be supported appropriately with their mobility needs, which put them at risk of falls and injury.

An accident record for one person stated that on one occasion they had begun violently shaking and slid out of their wheelchair. There was no additional information to show what action had been taken with regard to their health and well-being or action taken to mitigate the risk of a similar incident occurring. There had been no referral to a GP or to the falls prevention team following the incident. Staff told us that the person was prone to shaking which meant they were unable to have a shower as they were at risk of falling from the

shower chair. However, other than brief mentions of shaking in the daily records there was no mention of shaking in the persons care plan, the reason for this or the risks associated with this condition. The risk of falling from a shower chair was not recorded. These risks had therefore not been identified or considered and the person remained at risk of harm.

At our last inspection we found there was a lack of risk assessment and guidance for staff relating to the risk of potential seizures for one person. Despite this being discussed with the provider following the inspection, the appropriate guidance had still not been provided and the person remained at risk. Although the person had not had a seizure for many years they were diagnosed with epilepsy and took a daily medicine in order to control this. There was no risk assessment in place which considered risks such as potential for seizure should prescribed medicine not be taken.

Another person had recently returned from hospital following a fall and seizure. Despite two previous seizures, both requiring hospital admission, and signs recorded in the persons daily notes that a seizure may be about to occur, no risk assessment or care plan for seizure activity had been completed until the person returned from hospital. There had been no referral to the GP as advised by medical professionals on a previous hospital discharge summary. Staff had not been informed that the person was at risk of seizures or provided with the information they needed to help them recognise that a seizure may be about to occur and monitor accordingly. They had not been provided with training or guidance on what to do should a seizure occur. This meant the person had not been protected from the risk of harm.

Lack of staff knowledge regarding service users swallowing difficulties and support required due to this was highlighted at our last inspection in August and September 2017. Despite this, adequate control measures had not been put in place to ensure service users with swallowing difficulties were supported appropriately with their condition in order to keep them safe. We observed staff preparing fluids to a different consistency than stated in people's care plans. People continued to be at risk of receiving fluids in an unsuitable format, putting them at risk of aspiration or choking.

Care plans did not provide clear guidance to staff to protect people against the risk of developing pressure ulcers. A risk assessment in one person's care records showed them to be at risk of developing a pressure ulcer. However, an alternative risk assessment carried out on the same day by the same person indicated that the person was not at risk of pressure ulcers. Without consistent assessment of risk it was unclear what action was being taken to mitigate the risks of pressure ulcers developing or that staff had accurate information to be able to support people effectively.

The daily notes for one person referred to them becoming physically or verbally aggressive on a regular basis. However, there was no guidance for staff regarding how they should support the person when they became upset. The challenging behaviour risk management plan in the person's care records had not been completed and the chart intended to monitor these the person's moods and when they become agitated in order to identify potential triggers and strategies to promote and support positive outcomes for the person only included one entry with no analysis. This person had a diagnosis of dementia but there was very limited information regarding what this specifically meant for them as an individual and how they should be supported. We observed that this person was very unsettled during the lunchtime period, particularly as their lunch was delayed and they had to wait while others around them were eating. There had been no consideration given to how their distress could be alleviated by considering what situations were likely to cause them to become more anxious and agitated. Staff did not have the information needed to intervene effectively through de-escalation techniques or other agreed good practice approaches.

People were not protected against the risk of harm associated with the use of bed rails. One person received

all their care in their bed at their request. They were observed to have bedrails fitted to their bed which staff told us had been in place for several months. However, there was no mention of these being in-situ in their care records or assessment of risks associated with bedrails such as potential entrapment of limbs.

People were still not being protected against the risks associated with poor infection control. A member of staff informed us that they had removed jugs of drink from two people's rooms, which had a date sticker attached nine days previously. We discussed this with the nominated individual who confirmed this to be the case. This put people at risk of infection due to bacteria, which may have formed on the drinks. It also demonstrated that staff were not providing or promoting fluids for these people, putting them at risk of dehydration and associated health conditions such as urinary tract infections and confusion.

There had not been improvement in the systems for medication management. People's medicines were not being managed effectively to protect them from the risks associated with medicines not being given with an adequate time span between doses, as recommended by the manufacturer and prescriber. We observed one person being administered paracetamol at 10.55am and then offered an additional dose during the lunchtime medicines round. The exact time the person had taken the paracetamol in the morning had not been recorded. The medicines administration record (MAR) chart showed that the lunchtime dose had been refused by the person. Had they accepted the dose, they would have taken two doses too closely together putting them at risk of harm associated with the overdose of medicines.

Staff had failed to ensure that there were sufficient quantities of medicines to ensure the safety of people and to meet their needs. One person required a medicine prescribed to reduce their anxiety on a regular basis but had been without this medicine for three days as staff had failed to anticipate that this would be required and order before stock ran out. One member of staff told us, "This should have been anticipated and ordered given that [person] gets very anxious and requires it almost daily." This put the person at risk of un-necessary distress and at risk of harm due to escalating anxieties.

On the first day of our inspection we found that supplies of a food supplement prescribed for one person were not available. Although they had been ordered two days previously they had not yet arrived. This person was at risk of malnutrition and had been prescribed the food supplement due to weight loss. They had been receiving the food supplement for some time yet staff had failed to acknowledge that supplies were running low and anticipate the need to order further stock sooner. They had also not taken any other action in the meantime to replace or supplement this drink with something from their own kitchen or seek guidance on how to do so, until stocks arrived.

Two people were prescribed Alendronic Acid to be administered weekly. Staff had not been made aware of the specific protocol that needs to be observed when administering Alendronic Acid to ensure its safety and effectiveness. Although the senior member of staff was aware that people who were administered this medicine should stand or sit upright they told us, "I know about this from watching other staff doing the same." There was no guidance or protocol attached to the medicine administration records or information in the care plan regarding potential side effects. There was also no consideration of how this information would be communicated to the person or their ability to retain and act on this information. This put these people at a higher risk of complications associated with Alendronic Acid such as irritation of the oesophagus, causing them unnecessary pain and discomfort.

Another person was prescribed Warfarin. There was no guidance for staff regarding the potential complications associated with Warfarin such as the increased risk of severe or fatal bleeding. Staff were not provided with information to help them to look out for potential signs of haemorrhage such as bruising. This put the person at risk of unidentified medical conditions which, left untreated could be seriously detrimental

to their health.

This was a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff were aware of their responsibilities with regard to safeguarding people from abuse. However, they did not recognise or understand the wider aspects of safeguarding people from risk as identified in this report.

The provider had failed to learn from past mistakes or take action on shortfalls identified at our last two inspections in order to protect people from the risk of harm and/or abuse

This was a continued breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014.

Inadequate

Is the service well-led?

Our findings

At our last inspection in September 2017 we found that despite assurances and an action plan stating that improvements would be made following our inspection in June 2016, the provider had failed to establish effective systems and processes to assess, monitor and improve the quality and safety of the service, to ensure people received safe and effective care.

At this inspection we again found widespread and significant shortfalls in the way the service was managed and continued breaches of regulations. Despite our previous concerns the provider still did not have robust systems in place for effective oversight and governance, to ensure people were living in a safe environment, supported by adequate numbers of staff, competent in their roles and deployed in a way which met people's needs effectively.

Since our inspection in September 2017 management arrangements at The Oaks Residential Home had been extremely unstable and there had been five managers in post since this time. This had a direct impact on the quality of care provided. We were concerned that the seriousness of the situation at The Oaks, our findings and the tasks expected had not been fully communicated to potential new managers during the recruitment process. The new manager, confirmed to us that they had not been aware that the service was in special measures or that there were conditions on the provider's registration requiring them to take action to protect people from the risk of harm.

The Nominated Individual had been acting manager throughout the time when no other manager has been in employment. However, we found that they had poor knowledge of people's individual needs. Risk assessments and care plans reviewed by them were inconsistent or incomplete and did not identify all risks specific to each individual or demonstrate what control measures were in place to mitigate those risks. They were also unaware that the service was in special measures despite this being made clear in the inspection report published on 5 January 2018, which had been emailed to them, is available to view on our website, and was on display in the service.

The poor oversight and lack of leadership had resulted in a lack of structure and direction for the staff team. The provider had failed to promote a positive culture within the service and staff were unclear on their roles and responsibilities. Staff had not been provided with appropriate training or guidance to enable them to effectively carry out their role to allow them to provide safe and effective care. It had also led to a poor culture in the service.

Quality assurance systems in place had failed to identify the issues we found during our inspection, including shortfalls relating to staffing levels, risk assessment, inconsistencies in care records and the absence of information to be able to support people with all of their physical and psychological needs. There was a failure to recognise and identify significant failings affecting the quality of service provision. The provider had continued to miss opportunities to protect people from the risk of receiving inconsistent, inappropriate or unsafe care. Despite regular visits by the provider to the service since September 2017, there has been a continual failure to recognise and take action on the serious shortfalls we have found

during our last three inspections of the service.

We made the provider aware of the shortfalls we had found at this inspection and gave them an opportunity to respond. They provided assurances that the required improvements would be made now a new manager was in post. However, past assurances from the provider failed and people have continued to be at risk. Information supplied to us by the provider was in some cases misleading or inaccurate. For example, assurances that a system was now in place to ensure constant supervision of the communal areas was found to be inaccurate.

Failures in the service continued to be widespread and demonstrated the provider's inability to make and sustain improvements following our previous inspections in August and September 2017 and June 2016. This resulted in continued breaches of regulations and poor outcomes for people.

This is a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations

Following our inspection we immediately informed the provider of the seriousness of our concerns and required them to take urgent action to address these as we believed people were or may be exposed to the risk of harm if we did not do so.