

Oasis Community Care Ltd

# Oasis Community Care Ltd

## Inspection report

Ground Floor Office  
17 Callywith Gate, Launceston Road  
Bodmin  
Cornwall  
PL31 2RQ

Tel: 0120877159

Date of inspection visit:  
01 April 2016

Date of publication:  
11 May 2016

## Ratings

Overall rating for this service

Requires Improvement ●

Is the service safe?

**Requires Improvement** ●

Is the service well-led?

**Requires Improvement** ●

# Summary of findings

## Overall summary

We carried out an unannounced comprehensive inspection of this service on 1, 22, 23, and 25 July and 14 August 2015. After that inspection we received information in relation to the resignation of nine care staff who had resigned from their role within a period of seven days. Due to these resignations, the service was not able to deliver care to some people and their care arrangements were handed back to the Local Authority without notice. This raised concerns around how people's care needs would be met safely going forward. We were also concerned as we had not received a notification in relation to this matter in line with the providers obligations to make reports to us. As a result we undertook a focused inspection to look into those concerns. This report only covers our findings in relation to these topics. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Oasis Community Care on our website at [www.cqc.org.uk](http://www.cqc.org.uk).

Oasis Community Care Ltd provides domiciliary care services to adults within East Cornwall. On the day of the inspection Oasis Community Care was providing support to 85 people including people with physical disabilities, sensory impairments, mental health needs and people living with dementia.

The service had two registered managers in post. 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.

When we arrived at the service on 1 April 2016 we were met by the nominated individual. Neither of the registered managers were at work. We were told that Oasis Community Care Limited would be withdrawing from the delivery of care to people in their own homes ("stepping down") and that staff and all the people would be transferred to another local domiciliary care service. The nominated individual told us that this receiving agency had agreed to the transfer in principal and the plan was for the transfer to go ahead on 4 April 2016. With this change scheduled to take place imminently, we conducted a focused inspection to assure ourselves that people would be safe over the short time frame until the transfer took place.

We found that there were sufficient staff on the rota to ensure visits were covered until the transfer took place. There were contingency plans in place in case staff were sick and there was an effective on call system in place.

People's risk assessments were not always up to date This meant staff might not always have the most current information about how to support people. Peoples care plans had been found at the previous inspection in 2015 not to have been regularly reviewed. This issue was not addressed during this inspection due to the imminent handover of peoples support to another provider.

The registered managers did not have robust systems in place to assess the on-going quality and monitoring

of the service.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service safe?

Aspects of the service were not always safe.

People were not always protected from risks associated with their care because documentation relating to their care was out of date and did not reflect people's individual needs.

Short term arrangements were in place to keep people safe until the transfer of the service was arranged.

People told us they felt safe.

**Requires Improvement** ●

### Is the service well-led?

Aspects of the service were not well-led.

The registered managers did not have a robust quality assurance system To monitor the quality of the service being delivered.

People and relatives felt the management team were approachable.

Staff we spoke with were happy working for the service, but a significant number of staff had recently resigned.

**Requires Improvement** ●

# Oasis Community Care Ltd

## 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 was 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 a focused inspection of Oasis Community Care Limited on 1 April 2016. This inspection was carried out after concerns were raised. We inspected the service against two of the five questions we ask about services: is the service safe? and is this service well led?

The inspection was undertaken by two inspectors and was unannounced.

Before our inspection we reviewed the information we held about the service, including notifications received and concerns raised.

We spoke with three staff members and the nominated individual. The nominated individual is responsible for ensuring the personal care services provided by the organisation are properly managed. We also visited two relatives of people who used the service. We looked at three people's care records, staffing rotas, the complaint log and other documentation.

## Is the service safe?

### Our findings

People were at risk of not receiving all the support they needed. Risk assessments to provide guidance for staff on how to manage people's health care were not always up to date to help minimise any risks to the person.

Risk assessments not being in place as necessary, updated, and reviewed is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Short term arrangements had been put in place to keep people safe over the short time frame until the transfer of peoples support took place. This involved members of the management team providing care to some people to ensure all visits were always delivered. People told us "[the nominated individual] steps in often, perhaps once per week". The service had it's own rota coordinator who provided us with copies of the rota which we reviewed . We saw that all visits were covered until the scheduled transfer of the service.

There was an on call system in place and one staff member told us, "I am confident calls are covered over the weekend. Even if staff go sick we have enough staff to cover." Another staff member confirmed, "There is a good on call system and we have enough staff to cover the shifts."

The nominated individual told us they felt the remaining staff team were reliable and had been flexible in meeting people's needs. A staff member told us, "They are aware that if people have worked a lot of hours that they will need time off."

Staff told us they were not aware of any missed calls and if staff were going to be late, they always informed the person what time they would arrive. They also told us the staff who had left had all been from one geographical area and that as the support packages had already been passed to other services, these people were now being safely supported.

One relative we spoke with said " the carers are a bit flexible with times just lately, I think they are having some issues with recruitment but mainly they work to time".

Relatives felt that people received a safe service. Comments included "[my relative] is safe with the carers" and "I don't have any concerns about the service [my relative] is safe".

## Is the service well-led?

### Our findings

People's care plans had been found at the previous inspection in 2015 not to have been regularly reviewed. This issue was not addressed during this inspection due to the imminent handover of people's support to another provider.

The registered managers did not have robust systems in place to assess the on-going quality and monitoring of the service. For example, we reviewed an audit which indicated that care plans and risk assessments had been updated at the same time. This did not match the records kept which contained out of date risk assessments. In addition, the complaints log contained entries which described the nature of the complaint, but no evidence as to what action the organisation took as a result. We also looked at a telephone book which recorded people and staff calling the office and detailed what the call had been concerning, but not what the response had been. This meant that themes could not be identified and used to drive improvement of the service.

The systems in place to monitor the quality of service people received and to identify, assess and manage risks, were not effective. This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The nominated individual told us the nine staff resignations had occurred due to some staff losing confidence in aspects of the leadership of the service. The nominated individual said that concerns had only recently been raised and that acting to address these concerns would require the lead registered manager to withdraw from the organisation of care. A decision had therefore been made that Oasis Community Care Limited would withdraw from delivering any services at this time. The nominated individual told us they had contacted another registered care provider who would be able to take over the service. They told us, "I don't want to put anyone at risk. We are covering all the calls at the moment. I have been out when necessary to make sure they are covered."

The nominated individual told us they had not notified CQC of the staff resignations at the time they occurred, due to the pressure of the situation and prioritising covering shifts and keeping people safe. The nominated individual said this was an oversight and a notification was made retrospectively.

The nominated individual told us, "We have covered all the calls now. The people whose calls we couldn't cover due to lack of staff, we handed back to the council. We had to act quickly." A staff member confirmed, "We have a duty of care to people. We had to hand those care packages back to (Cornwall Council) ensure quality of care for the other people we provide care for." They also told us, "We're trying hard to maintain high standards whilst we work through these difficulties."

The nominated individual had arranged staff meetings for the following week to ensure people were kept up to date with any changes. Staff told us, we have back up if we need anything out of hours and we can always get hold of the nominated individual if we need them.

Relatives we spoke with confirmed that the management team were approachable. Comments included; "If I had a concern or complaint, I'd feel confident to call the office", "If I had a problem I'd raise it" and "[the nominated individual] is approachable, I'd contact the office with any concerns".

Staff we spoke with were positive about the service. Comments included; "Everyone is positive and helpful, it's a nice organisation to work for" and "[the management team] are approachable and always contactable".

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment  Risk assessments not being in place as necessary, updated, and reviewed is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance  The systems in place to monitor the quality of service people received and to identify, assess and manage risks, were not effective. This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.