Ardale (Oakham) Limited

Oakham Grange

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?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Oakham Grange is a care home with nursing. Accommodation is over three floors. All rooms are en-suite and there are a range of accessible communal areas and outside areas. The service can accommodate up to 68 people, some of whom are living with dementia. At the time of our inspection 49 people were using the service.

People's experience of using this service and what we found
People's health needs were not safely supported. Staff did not have clear guidance on how to support people's needs. Staff did not record when clinical care was provided to people, so we were not assured that people received clinical care as planned. There were no nurses in the service at night-time – which left people at risk. There were safe recruitment checks to ensure staff were of good character. People reported that there were enough staff to respond to their needs, but staff did not always have time to spend with them. Medicines were not always managed safely and lessons were not always learnt to ensure improvements were made to care.

Staff were not always suitably trained to complete safe care. Nurses did not receive recent clinical supervision or competency assessments to ensure they were suitably skilled. People were not always supported to have maximum choice and control of their lives and staff did not always support them in the least restrictive way possible and in their best interests. People were given enough to eat and drink. Some people required altered textured food and drink to ensure they could swallow safely. This had not been altered safely for 1 person - which put them at risk of choking. People received support to access support from external health and social care professionals but people's healthcare needs were otherwise not well supported by staff.

People told us that staff were kind and treated them with respect. However, people felt that staff sometimes did not have time to spend with them. We saw people were given privacy as needed.

Care was not always personalised to people's preferences as staff did not have specific guidance on people's unique needs. We were not assured that people would receive good quality end of life care. This is because most staff had not received end of life training. People's communication needs were met. People were able to engage in activities at the home. The management team responded to individual complaints about care to ensure improvements were made.

The management team were aware that action was needed to improve Oakham Grange. There was a quality improvement plan in place and some actions had started to take place. However, we were not assured that this was resolving concerns at the service in a quick enough way to keep people safe. When we raised concerns during the inspection, further action was taken by the management team – for example arranging for staff training.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection
The last rating for this service was good (published 28 April 2022).

Why we inspected
The inspection was prompted in part due to concerns received about medicines and allegations of neglect. Specific allegations were still being investigated by the local authority safeguarding team. We made a decision to inspect and consider risks at the service.

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

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

Enforcement
We have identified breaches in relation to safe care and treatment, staffing, consent and governance. Please see the action we have told the provider to take at the end of this report. We have sent the provider warning notices. These give the provider a specified amount of time to make improvements. We will then inspect to review if the required improvements have been made.

Follow up
We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe and there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the 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? The service was not safe. Details are in our safe findings below.	**Inadequate**
Is the service effective? The service was not effective Details are in our effective findings below.	**Inadequate**
Is the service caring? The service was not always caring Details are in our caring findings below.	**Requires Improvement**
Is the service responsive? The service was not always responsive Details are in our responsive findings below.	**Requires Improvement**
Is the service well-led? The service was not well led Details are in our well led findings below.	**Inadequate**

Oakham Grange

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Health and Social Care Act 2008.

Inspection team
The inspection was completed by 2 inspectors.

Service and service type
Oakham Grange is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Oakham Grange is a care home with nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was a registered manager in post. We did not meet the registered manager as they were on long-term leave during our inspection.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We requested the provider sent a provider information return to us. This information was returned to us the day before the inspection. We therefore reviewed this response while completing the inspection. This is

information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make.

We contacted Local Authority stakeholders to review any current safeguarding concerns and results of recent audits.

During the inspection
We spoke with 6 people who used the service and 6 relatives.

We also spoke to 10 members of staff. Including the deputy manager, nominated individual, the nominated individual is responsible for supervising the management of the service on behalf of the provider, head of quality and compliance, 2 chefs, 3 qualified nurses and 2 care workers.

We reviewed a range of records. This included the relevant parts of 9 people's care records and multiple medication records. We looked at 3 staff files in relation to the safety of recruitment. A variety of records relating to the management of the service, including policies, training records and procedures were also reviewed.

Inadequate

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At our last inspection we rated this key question good. At this inspection the rating has changed to inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management

● Not all staff had access to care plans to guide them on how to support people. The service used agency staff to support people and these agency staff only had access to summary guidance rather people's full care plans. These summary guidance sheets did not include enough detail for agency staff to care for people safely. For example, a person required urgent 'as needed' medicines for a serious health condition and this information was not included on the summary sheet. This risked the agency staff member not being aware of the need to administer these urgent medicines in a timely way.

● Staff did not have sufficient guidance to support the safe use of in-dwelling medical devices. In-dwelling medical devices are attached to a person to give them nutrition, remove bodily waste and give intravenous medication. Multiple people at the service were reliant on these devices for their health. Staff either did not have any guidance or had poor quality guidance on how to use these medical devices safely for people. This put people at risk of unsafe care when staff supported the use of this medical equipment.

● People did not always receive suitable care for their indwelling medical devices. A person's equipment entered via their skin. The provider's policy required staff to record that they had checked the site for infection. Staff did not note all required skin checks had been completed. We were therefore not assured that suitable checks occurred. There were also gaps in record keeping, suggesting that care had not been provided as planned. For example, one person required a new weekly dressing where the medical device entered their skin. This dressing change had not been recorded for 2 weeks in a row. We were therefore not assured that the required dressing had occurred as planned. This put the person at high risk of infection.

Using medicines safely

● Where concerns had been identified around medicines management, these were not acted upon in a timely way. The management team had requested that staff complete stock checks on medicines. A stock check will count how much medicine is expected to be in stock and then count the medicine in the building to ensure it matches up. This can help to identify if a medicine error like over/under dosing a person had occurred. A stock check completed 2 days before the inspection had identified multiple stock errors. However, the reasoning behind these errors had not yet been investigated. We would expect a stock error to be investigated immediately to assess if a person using the service is at risk of harm from a medicine error and seek medical advice. After the first inspection day, the management team investigated this stock check. They found 1 person had missed their medicine 4 times – twice in February and twice in March. Our inspection occurred in April. These February and March errors not being identified and acted upon sooner placed the person at increased risk of harm.

● A person received their medicine through a syringe driver. A syringe driver gives a steady stream of medicine via the person's skin. Staff had recorded on daily notes that this syringe driver had broken but

there were no further details of what they had done to ensure the person was safe from an under-dose of medicine. The person's care plan also did not give staff enough guidance on how to care for this syringe driver safely.

● A person had difficulties swallowing so had been prescribed an altered diet to prevent choking. Staff explained that this person was given medicine which they needed to chew before swallowing. These tablets were only prescribed to be swallowed whole, so we were not assured that they were administered safely when chewed. The person's ability to swallow these chewed tablets had also not been clearly risk assessed to ensure it was safe. The management team responded by contacting medical professionals for a change in the person's prescription.

●Topical patches of medicine can be applied to people's skin to provide regular pain relief. These types of medicines were not recorded safely at Oakham Grange. Staff recorded when they applied the medicine patch but did not record checks that the skin patch remained in place. Shortly after the inspection, we received a concern that a person's pain related patch had come off and due to the lack of written checks it was not clear when this patch had come off.

People were not always kept safe from the risk of harm. This is due to poor risk management and the unsafe use of medicines. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong

● People were not kept safe from abuse. An incident form completed by staff had recorded that a person living at the service had hit another person. This is physical abuse. This concern was not referred to the local authority safeguarding team to investigate until a week later -when the inspector raised concerns about the incident. The person's care plan had also not been updated to guide staff on what to do if this person was verbally or physically aggressive to other people in the future. The inspector flagged this concern and while the care plan was updated, the update was poor quality as it still did not give staff sufficient information to guide them on if this situation occurred again.

● We identified a current safeguarding investigation being completed by the local authority. This investigation was into concerns about a medicines error. The person's medicine related care plan had not yet been updated to prevent similar medicine errors happening in the future.

● People were at risk of neglect and this had not been identified prior to our inspection. Records suggested that people did not receive their clinical care as required. For example, a person was supposed to have their catheter drained regularly but notes kept by staff suggested this was not done as often as needed. This risked the person becoming unwell. This record keeping had not been reviewed to assess if this was a record keeping concern or people were being neglected.

People were not always kept safe from abuse. This was a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

● At the time of the inspection, there were only nurses employed in the daytime. There were no nurses overnight at Oakham Grange. The management team were aware that night nurses were needed and were in the process of recruiting and were using an on-call system for care staff to phone a nurse if needed. While this recruitment occurred, we were concerned that people were at risk during the night-time. This is because care records did not give enough guidance for when non-clinical staff should call for a qualified on-call nurse. In addition, a person was likely to require urgent nurse support for an expected health condition. This on-call system would not allow a timely response to keep the person safe from harm.

● We expressed concerns about the lack of nurses overnight, and the management team arranged for

agency nurses to be on-site until permanent recruitment was finalised. We reviewed the skills profiles of these nurses and remained concerned that the clinical skills needed to work at Oakham Grange were not clearly recorded. We expressed concern to the management team who advised they had asked the agency for suitably skilled nurses but would investigate these nurses' skill set to ensure they were safe to work at Oakham Grange.

● All people and some relatives we spoke to reported that there were not enough staff. They reported that they sometimes needed to wait for staff to be available in communal areas. People and relatives reported that this did not impact their urgent needs. A staff member said, 'We don't have enough time to provide personalised care'. We observed and electronic records supported that there were enough staff to respond to emergency buzzers being pressed.

● Records showed that the service used agency staff. As described in 'Assessing risk, safety monitoring and management' these agency staff did not have access to sufficient guidance to care for people. A relative and person using the service explained that the agency staff did not seem to know the procedures of the care home. This placed people at increased risk of harm, when receiving care from agency staff.

There was not always suitably skilled staff deployed around Oakham Grange. This was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff were safely recruited to ensure they were of good character. For example, staff had disclosure and barring checks (DBS) to ensure they were of good character before starting employment.

● In response to concerns raised on inspection, the management team arranged for increased nurses during the day-time. We will assess the impact of this at our next inspection.

Preventing and controlling infection

● Records showed that a person had previously been diagnosed with COVID-19. Staff had found it difficult to isolate the person to prevent transmission of the condition. This was due to the person's mental health and related agitation. There was no person-specific care plan in place on how to prevent COVID-19 transmission if this person tested positive again. We raised this with the management team who advised a specific plan would be created in the event the person was diagnosed with COVID-19 in the future. We would expect this plan to be in place and shared with staff in advance of the testing positive for COVID-19, so were not assured by this response.

● We were otherwise assured that the provider was preventing visitors and people living at the service from catching and spreading infections.

● We were assured that the provider was admitting people safely to the service.

● We were assured that the provider was using PPE effectively and safely.

● We were assured that the provider was responding effectively to risks and signs of infection.

● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.

● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.

● We were assured that the provider's infection prevention and control policy was up to date.

Visiting in care homes

The providers approach to visitors, was in line with the government guidance.

Inadequate

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

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

Staff support: induction, training, skills and experience

- Staff had not received training in how to support people when they were agitated. The service supported people with dementia who could display behaviour when they were distressed. Staff reported a person could display particularly complex behaviour due to their diagnosis. However, staff did not feel confident to support this person during these periods of distress. One staff member said 'We worry about giving personal care as [person's name] can attack. We've not had training for challenging behaviour. I don't feel comfortable doing their care so we go in pairs."
- Nursing staff had not received recent clinical supervision. Clinical supervision is a formal process of support for the nurse to reflect, learn and develop. Nursing staff had also not received regular competency checks. The absence of clinical supervision and competency checks meant we were not assured the nurses skills were kept up to date.
- Care staff had not received training in catheter care and understanding urinary tract infections. Some people at the service required catheters. Care plans for this catheter need also did not provide the staff with enough guidance. We were therefore not assured the staff were suitably skilled to support people' urinary needs.
- Staff were not suitably skilled to provide altered diets. The International Dysphagia Diet Standardisation Initiative (IDDSI) provides national 'levels' that food should be altered too. For example, a level 5 diet should have food pieces that is no greater than 4 millimetres in size. While the kitchen staff had written details of the IDDSI on the kitchen wall, only 2 out of the 4 kitchen staff had received training on altered diets. This risks them providing incorrectly altered food to people.

There was not always suitably skilled staff to support people's needs effectively. This was a breach of regulation 18 (staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The management team advised that they intended to arrange further training for staff. At the time of the inspection, this had not yet been fully arranged. We will assess the impact of this at our next inspection.

Ensuring consent to care and treatment in line with law and guidance

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The MCA requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

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

● People's ability to make decisions were not clearly assessed and recorded at the service. For example, the service had recognised that the use of bed rails restricted a person's freedom. They had therefore completed a deprivation of liberty referral. However, they had not assessed the person's mental capacity to see if the person could make a decision about these bedrails before putting them in place.

● People's care plans stated, 'does not have capacity to make decisions as defined by mental capacity act 2005.' The mental capacity act states that the act should be considered in relation to specific decisions. For example, a person may be unable to make decisions related to finances, but can make a decision to have a drink if they are thirsty. Records did not provide further guidance to staff on what decisions a person could or could not make – this generic statement in care plans risks staff not gaining consent for specific decisions.

Systems were not effectively established or implemented to ensure people provided their consent for their care. This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to eat and drink enough to maintain a balanced diet

● Multiple people using the service required an altered diet or drinks. This is to aid swallowing and prevent choking. We saw that 1 of these people received food that was the incorrect texture, this could risk them choking. The management team were responsive to this concern and updated the kitchen team about the person's needs.

● People received enough to eat. Feedback about the quality of food was variable from people using the service. Where people were unhappy with the type of food served, they advised they had been given the opportunity to feed this back and were hopeful that improvements would be made.

● People received enough to drink. Records were kept on when people had a drink so trends in hydration could be monitored.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

● People's social, mental and physical needs were not holistically assessed. Care plans did not always provide clear guidance to staff, to ensure that people's diverse needs could be effectively met. For example, a person's care plan described their mental health needs within a care plan titled 'physical health'. There was a lack of detail in the care plan on how to support the person's physical health needs.

● Some people had motion/pressure sensors. These alerted staff if the person moved, so they could attend quickly. We saw this system was not always effective. A person was supposed to have a sensor on both their bed and chair. We observed the sensor was only on the persons chair and not on their bed. Staff visited the person but did not resolve this missing bed sensor. Later, we saw the chair sensor was underneath a cushion which can impact it working effectively. We were therefore not assured about the use of these sensors. We raised this with the management team, who communicated with staff about how to safely use these sensors.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support.

● People were not supported to live healthier lives. This is because care plans did not provide enough guidance for staff on how to care for people's physical health needs. Records suggested clinical care was not always provided as planned.
● We saw a record where staff had requested medicine for a person's emotional distress. The doctor had responded that the staff needed to first monitor the person's behaviour before medicine was prescribed. After this, records kept by staff were not clear enough. For example, staff wrote 'was a little aggressive. They are calm now.' This does not give enough detail on what triggered the person's agitation, how they person presented, what staff did to support the person and whether the staff action was effective. Poor record keeping meant staff could not effectively pass information to the person's doctor to assess the future need for prescription medicine.
● People told us they had access to health and social care professionals as needed. One person said, 'they are really quick to call the doctor if I need him". Records showed that external health and social care professionals were called when needed.

Adapting service, design, decoration to meet people's needs
● People had access to call bells to call for support as needed. We saw staff respond to these bells quickly when pressed. The management team had completed audits of call bell response time. These audits showed a quick response was usual practice.
● Oakham Grange is a purpose-built building, the design and layout met people's needs
● People had access to specialized equipment like hoists to ensure they could mobilize when needed.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Ensuring people are well treated and supported; respecting equality and diversity

- People told us staffing levels in the home could impact the amount of time they spent with staff. One person said, 'They are kind enough – but they just aren't always there when you need them or want to ask a question.' A relative said "The feedback I get from mum is that she could do with more attention." Despite feedback staff did not always have time with people; overall feedback was that staff were friendly, approachable, and kind.
- Staff were kind to people when they interacted with them. For example, a staff member asked what a person would like to drink and then checked the temperature of the drink was okay for them. However, these kind interactions were focused on getting tasks completed and not people's wellbeing.
- The service had an equality policy and staff had received training in equality and diversity. This helped staff care for people's unique needs with respect.

Supporting people to express their views and be involved in making decisions about their care; Respecting and promoting people's privacy, dignity and independence

- Staff asked people's permission before engaging in care tasks. For example, staff asked a person where they would like to sit in the lounge and supported them to get there.
- Staff knocked on people's bedroom doors before entering. They then asked if the person would like the door open or shut when they left. While staff were in people's rooms, they ensured the bedroom door was shut before completing private personal care tasks. This meant people were given privacy.

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences.

- Care plans did not always reflect people's personalised needs and preferences. Agency staff did not have access to full care plans so had very limited information on people's preferences. This lack of guidance can impact staff's understanding of how to support people. Relatives told us they felt improvements were starting to be made. One said "Some information appeared on the table yesterday asking about mums likes and dislikes. I have not seen anything like that before at the home."
- Some people felt staff did not always know how to support their needs. One person said "They ask me how to do things. They should have guidance on what to do and not ask me how to look after me."
- People reported a suggestion box was in place, however when they had made suggestions using this, they felt changes had not happened quickly. One person was concerned that each person needed to buy their own newspaper. They would like to share a newspaper with their friends to save money – however felt care staff had not acted on this request.

End of life care and support

- Only 20 out of 35 staff had received training in end-of-life care. This placed people at risk of these 15 staff not knowing how to care for people effectively at the end of their lives.
- We reviewed a person's end of life care plan and this was not good quality. The person's health condition meant they could have a sudden death at any time. Staff were not clearly guided on how to respond to a sudden deterioration or how to administer the persons required end of life medicines in a timely way. We raised this concern to the management team and the care plan was updated. It still did not include the required information on the person's end of life medicines, so we requested a further update.

Meeting people's communication needs

Since 2016 all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard. The Accessible Information Standard tells organisations what they have to do to help ensure people with a disability or sensory loss, and in some circumstances, their carers, get information in a way they can understand it. It also says that people should get the support they need in relation to communication.

- People's sensory needs like hearing and eyesight were recorded in care plans for staff to follow. A relative told us that staff had recognised a person's increased hearing loss and contacted a medical professional for advice.
- Staff were seen to communicate with people in a way they understood.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow

interests and to take part in activities that are socially and culturally relevant to them

● People told us there were activities to engage with at the care home. One person said "we can always go for trips. I'd like to go out more and I only need to ask."

● We saw animal therapy was at the home on the day that we inspected. This is where animals are brought round to the residents to engage with. We saw residents had a positive reaction to this.

● Relatives told us they were free to visit the care home as they wished.

Improving care quality in response to complaints or concerns

●The management team recorded complaints to monitor for themes. Complaints were responded to in a timely way.

● People and relatives that we spoke to, told us that they had not had a reason to make a formal complaint.

Inadequate

Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

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

Promoting a positive culture that is person-centered, open, inclusive and empowering, which achieves good outcomes for people; Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

● Oversight of people using indwelling medical devices was poor. Indwelling medical devices are attached to a person to give them nutrition, remove bodily waste and give intravenous medication. Staff did not always have clear written guidance or training on using these medical devices. Care records had gaps, suggesting that the expected care of these devices had not occurred. These concerns can lead to serious ill health for people using these devices. Governance checks at the service had not recognised and resolved these concerns.
● Care plans were poor quality so they did not always guide staff on how to support people. The management team recognised care plans needed improvement and advised plans were in place to improve them. However, staff had reviewed people's care plans regularly and these reviews had not resulted in plans being improved in a timely way.
● In January 2023, the management team had audited mental capacity records for people using the service. The audit identified concerns with different people's mental health and mental capacity records. However, the inspection in April 2023 found the records had the same errors in place. The management team were aware that further improvements were needed and were arranging staff training. However, timely action had not taken place to ensure improvements were actioned.
● The management team had created a quality improvement plan to improve the service. This plan did not include all concerns we identified. It also did not have clear timescales or priorities for concerns raised. We raised this as a concern and an action plan was sent to us. We returned to the service a week later and saw further action had been taken to make improvements however these were prompted by the inspection team.
● Quality assurance tools had failed to identify that staff did not keep clear records on what care was provided to people. For example, The International Dysphagia Diet Standardisation Initiative (IDDSI) provides national 'levels' that food should be altered to aid a person's swallowing. For example, 'level 4' food cannot be sucked through a straw, whereas 'level 3' food is a consistency where it may be sucked through a straw. Care staff wrote that the person ate 'pureed' food. The word 'puree' does not clearly show how the person's diet was altered to meet their prescribed 'level'. We saw the person was given the wrong level of food which put them at risk of choking.
● Quality assurance tools failed to identify that staff did not always complete care plans with information that was needed. For example, a person's care plan described that they did not have diabetes. The care plan

also described that if the person had high or low blood sugar levels or symptoms then certain action could be taken by staff. High and low blood sugar symptoms would not occur unless the person had a diagnosis of diabetes. If the person experienced symptoms then this would be unusual and medical advice would be needed. We spoke to a nurse about this, they said 'For some reason staff are creating a care plan for everything. There is no need for a diabetes care plan because [person's name] doesn't have diabetes. So, they didn't need to write it.' The management team had recognised that staff needed more guidance on how to write a care plan, however improvements had not yet occurred.

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

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

● Some people felt the management team were not approachable. One person said, "We never see the managers. If you pass them – they never say hello". Another person said, "Its poorly managed – you never see the manager. When I was at another home, the manager would do a daily walk around and I got to know them. But they just stay in their office here".

● The service had begun efforts to make people more aware of the staff team. Photos of managers and staff were around the building with a description of the staff member's likes and dislikes. A member of the management team advised this was a recent addition to improve relationships between people, relatives and staff.

● The management team engaged with staff via surveys. Survey outcomes suggested that feedback was becoming more positive. Plans were in place to complete regular surveys with people and relatives.

● Staff were able to attend regular meetings to receive updates on the service. When we raised concerns during the inspection, we saw communication was sent to staff to aid improvements.

How the provider understands and acts on the duty of candor, which is their legal responsibility to be open and honest with people when something goes wrong; Continuous learning and improving care

● The management team were open and transparent about concerns at the service. They responded to concerns raised by the inspection team by starting to make changes to the service. For example, we identified that some people were prescribed anti-coagulant medication. This type of medication prevents blood from clotting effectively. Staff did not have guidance on how to respond if these people fell over, as this medicine can put the person at increased risk of internal and external bleeding in the event of an injury. We raised this to the management team and the following day they sent us guidance they had now created for each person. We remain concerned that this risk had not been identified and resolved prior to our inspection but were reassured of the pro-activity of the management team.

● While some action taken in response to the inspection was positive, we were not always assured. For example, we requested people's care plans were updated to provide suitable guidance for staff. Some updates completed by the management team were still not of a suitable standard.

● The service is legally required to notify us of certain events that happen. We have been notified as expected.

Working in partnership with others

● The management team said they were aware of previous medicine concerns and were working with the pharmacy and their staff team to make improvements to medicine safety. This action had not yet resolved the medicine concerns seen on inspection (See the 'Safe' domain for fuller details)

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent People's decision making was not always clearly documented in line with the Mental Capacity Act (2005). This was a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment People were not always kept safe from abuse. This was a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People were not always kept safe from the risk of harm. This is due to poor risk management and the unsafe use of medicines. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

We have sent the provider a warning notice. This gives a specified time period to make required improvements

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Governance at the service recognised that improvements were needed. However, it had not resulted in improvements being made in a timely way. This was a breach of regulation 17 (good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

We have sent the provider a warning notice. This gives a specified time period to make required improvements.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing There was not always suitably skilled staff deployed around Oakham Grange. This was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

We have sent the provider a warning notice. This gives a specified time period to make required improvements.