Oakdene Residential Home Limited

Oakdene Residential Home

Inspection report

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26 November 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 unannounced focused inspection took place on 23 and 26 November 2018.

We had carried out an unannounced comprehensive inspection of this service between 9 and 16 August 2018. After that inspection we received information of concern in relation to a lack of heating and hot water at the home. As a result, we undertook this focused inspection to look into those concerns. This report only covers our findings in relation to the questions; 'Is the service safe?' and 'Is the service well-led?' You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Oakdene Residential Home on our website at www.cqc.org.uk

The home is registered to provide accommodation and personal care for up to 16 people. At the time of our inspection nine people were living at the home.

The home required and had a registered manager. 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 delegated the day to day running of the home to a relief manager. The relief manager had been working at the home since March 2018, however the registered manager is still legally responsible for the safe running of the home.

During our previous inspection in August 2018 we again rated the service overall 'Inadequate'. Since January 2018 the service has been in 'special measures'. This inspection did not change the rating of this service.

At this inspection in asking the questions; 'Is the service safe?' and 'Is the service well-led?' we found continued breaches of Regulation 12, 17, and 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. There was also a continued breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009. There was no longer a breach of Regulation 13, as systems had been improved at the service that helped protect vulnerable adults from abuse.

When we arrived at the home the central heating and hot water were not working. The service was using multiple portable electric heaters. The communal areas of the dining room and lounge felt warm and people told us they were warm.

The provider had taken some steps to ensure that people were warm in the home. However, they had not done this safely and ensured that additional risks had been mitigated. We asked the provider to complete a risk assessment for each individual to identify and minimise the risks of using portable electric element heaters; to keep regular temperature checks of the home to stop it becoming too hot or too cold; to place an extra member of staff on duty over the weekend to provide additional checks and to stop using items to wedge open fire doors.

We returned on Monday 26 November 2018 and found that a new heating and hot water system had been fitted and that the service had put the safety measures requested in place. The home was warm.

The old boiler had been identified as being, 'immediately dangerous' on the 14 November; ten days earlier and the gas supply had been capped. The gas safety certificate for this appliance and the gas supply had been allowed to run out of date twelve weeks earlier. The provider had not informed the CQC of this. It is It is clear in the Care Quality Commission (Registration) Regulations 2009 that this is a reportable event; this shows a pattern of the provider not providing the CQC with information that they have a legal obligation to do so.

There were also other safety risks with the environment identified during this inspection.

The leadership at the home was still reactive. The registered manager and the systems in place were not yet identifying areas requiring immediate improvement and ensuring that appropriate actions were being taken and necessary improvements were being made to ensure that the care and accommodation provided was safe and of high quality.

There had been improvements in the management of people's medication, still further improvements were required. There was still insufficient information held on each staff member used at the service, as highlighted previously.

There were improvements in how accidents and incidents were recorded and managed at the home; in how people's mail and healthcare appointments were managed; food safety and people's financial records.

People told us they liked living at the home, that they felt safe and had been warm in the week before our inspection.

The overall rating for this service is still '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 registered provider's registration of the service, will be inspected again within six months of the last comprehensive inspection report.

The expectation is that registered 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 registered 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 registered provider from operating this service. This will lead to cancelling their registration or to varying the terms of their 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.

Steps had not been taken to ensure the environment of the home was safe. Essential safety checks had been allowed to expire.

Medication administration was not always safe.

Appropriate records were not in place for all staff working at the home.

Is the service well-led?

Inadequate

The service was not well-led.

Systems in place were still not ensuring that necessary improvements were being made to ensure that people's care and accommodation was safe and of high quality.

The provider had not made all the statutory notifications to the Care Quality Commission, that they were obligated to make.

Oakdene Residential 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 23 and 26 November 2018; the inspection was unannounced. It was carried out by three adult social care inspectors and an inspection manager. An inspector and an inspection manager made a brief visit on the 23 November to ensure people's safety and a more in-depth inspection took place by two adult social care inspectors on the 26 November. We had received information of concern in relation to a lack of heating and hot water at the home for a period of ten days. As a result, we undertook a focused inspection to look into those concerns. Before our inspection we spoke with the local authority to gain their perspective about the service.

We looked at the environment of the home and records relevant to the quality monitoring of the service. We looked round the home, including people's bedrooms, the kitchen, bathrooms, garden and the lounge areas.

We also spoke with four people who lived at the home and one person's relative.

We spoke with staff working at the home; including two members of care staff, the registered manager, the relief manager and a director of the company which owns the home.

Inadequate

Is the service safe?

Our findings

During our inspection in October 2016 we identified breaches of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the provider had not ensured that the premises and equipment were safe to use and were used in a safe way.

At our inspection in January 2018 we found that the provider had failed to make all the required improvements. There was a continued breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During our inspection in August 2018 we found that the provider had continued to fail in ensuring the premises were safe to use.

This focused inspection on 23 and 26 November 2018, was in response to information of concern received by the CQC. We received information that the home had no heating or hot water, and this had continued for over a week. The provider had not informed the CQC of this as they are obligated to do so when a registered home is without an essential service, such as heating for over 24 hours.

We started a focused inspection on Friday 23 November. When we arrived two social workers from the local authority were present. They told us that the service had arranged for a GP to visit and review the health of four people living at the home. The social workers also informed us that people told them they did not wish to move out of the home.

The central heating and hot water boiler were not working. We saw that portable electric heaters were being used in each person's bedroom and in communal areas of the home. One electric shower was available for people who wished to use it and an electric water heater was able to provide some hot water. The service had arranged for heating engineers to fit a new heating and hot water system over the weekend of 24 and 25 November 2018.

The communal areas of the dining room and lounge felt warm. People using the lounge also had blankets covering them, they all told us that they felt warm. One person was in their room with a portable electric heater on, the person told us that they were warm enough. Some of the rooms we entered felt very warm.

The provider had taken some steps to ensure that people were warm in the home. However, they had not done this safely and ensured that additional risks had been mitigated. For example, Individual risk assessments had not been completed to identify and minimise the risks of using portable electric element heaters. For example, increased risks of people falling or burning themselves.

Three people's rooms had the fire doors propped open, two by chairs and one by a portable heater. We advised the relief manager that this was not safe as it stopped the fire doors from keeping people safe in the event of a fire, especially during the time of increased risk while using multiple electric heaters. This is something that we have previously brought to the attention of the provider. Also, the body of the heater in

one person's room was very hot to touch.

No temperatures at the home were being recorded and no thermometers were available to be able to do so. We spoke with the relief manager of the danger to vulnerable adults of being too cold or too warm. We told the relief manager to regularly take the temperatures of the communal areas and people's rooms, throughout the day and night. That an extra member of staff was available to ensure people didn't trip over power cables and to complete extra checks on people and the safety of the portable heaters, as multiple portable electric heaters pose an increased fire risk. We also asked the relief manager to complete a risk assessment for each person due to increased risks and update the home's fire risk assessment. We alerted the local fire service of the increased risks at the home; they were happy with the arrangements put into place.

We returned on Monday 26 November and found that a new heating and hot water system had been fitted. Records of temperatures had been kept over the weekend and we were told that an extra staff member had been deployed. The home was warm and the portable electric heaters were no longer being used. The new boilers had been fitted in one of the rooms of the basement. We recommended that the provider update the fire risk assessment and seek the advice of a competent person to ensure that the room in the basement now used for the boilers had adequate fire protection.

We looked at the records for the previous boiler and saw that this had stopped working and had been identified by a competent person as being 'immediately dangerous' on the 14 November 2018 . The most up to date record of a gas and boiler safety check was dated 23 August 2017. The Gas Safety Regulations 1998 outline the responsibilities of people providing accommodation; these include annual safety checks on gas appliances and flues.

A director of the company who took the lead in building safety, refused to answer questions regarding when the boiler and gas supply was last checked. The registered manager told us, "It may well have been overlooked due to the fact of everything going on at the home at the moment." They also told us that they had not had any trouble from the boiler in 26 years.

After our inspection we received an email from the relief manager telling us that the annual safety check was allowed to elapse on 23 August 2018; twelve weeks before the boiler failed and was deemed 'Immediately dangerous'.

The systems in place to ensure the environment was safe did not stop this from happening. On the 27 August 2018 the relief manager had completed a 'Quarterly Health and Safety Checklist'. This check highlighted that the annual gas and boiler checks were overdue but there was no action identified.

On this inspection that there was a risk assessment in place for the ongoing refurbishment work. One of the risks highlighted was mitigated by tools being kept in a locked room when unattended. However, room number ten was not secure and contained builder's tools such as saws, hammers and chisels, along with power tools. In another room a ladder was accessible to people. This showed that the risk assessment was not being followed and checks of the environment had not highlighted this.

There were other areas of concern in the environment. For example, the upper stair lift had a broken cover at the top of the track, this exposed electric wires that were unsafe and a tip hazard. A wall light in the corridor close to the manager's office had a broken glass lightshade which exposed sharp glass edges, the wall light was not very high and could be easily reached. Also, the wall light was pointing down and had two missing bulbs which meant that somebody touching the light may receive a shock from electric contacts. We were

told by the registered manager that the light was not connected and therefore was not live. This was not true; the light fitting was live. There was a trip hazard from the carpet in the hallway, we asked the relief manager to secure this temporarily.

We checked two first aid boxes and these were still not adequately stocked. Call bells in people's rooms made an audible alert on the ground floor for staff, however they did not identify a person or room number from which the call was made. This has the potential to delay people receiving help from staff when needed. One person's call bell had not been working for a couple of days, this had caused them some distress. It was fixed during the last day of this inspection.

Sufficient attention had not been given to ensuring the safety of the environment at the home and the provider has repeatedly been reactive and has not assured themselves, by the means of effective checks or audits that the environment of the home was continually safe.

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

During our inspection in August 2018 we found that the provider was in breach of Regulation 17 in regard to the recording the administration of medication to ensure that it was safe. At this inspection the records of medication administration had not improved sufficiently to ensure that medication administration was safe.

For example, the amounts of medication received was not always recorded. Also for some medication where one or two tablets could be administered, the amount administered was not recorded. This meant that staff could not be sure that the stocks held were correct. Usually checks of the stocks held against records is used as an indicator that people have received the correct medication. We checked the stocks of seven medicines and three differed from what was expected on the records, this included one medication susceptible to abuse were more robust recording was needed. However, we could not check if errors had been made because records had not been kept as described.

The storage temperatures of medication were not taken and handwritten information on administration records did not contain direction for staff on the administration of the medication. Guidance was not always available for staff on 'as and when required' (PRN) medicines.

Appropriate records had not been kept to help ensure medication administration was safe. We recommended that the registered manager made themselves and the relief manager aware of available best practice guidance on the safe management medication in care homes.

This is a continued breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

No new staff had been recruited at the home since our inspection in August 2018. There were still three people working at the home by an arrangement with a third-party care home. They were not employees of Oakdene Residential Home; however, the registered manager still needs to assure themselves that they are of good character and are suitable to work with vulnerable adults. They cannot transfer this responsibility to a third party. At this inspection the registered manager had continued to fail to maintain a record of all the required information about staff members.

This is a continued breach of regulation 19 of the Health and Social Care Act 2008 (Regulated Activities)

Regulations 2014.

During our inspection in August 2018 we saw that there were sufficient staff to meet people's needs, this was because the number of people staying at the home had reduced.

Since our last inspection the staffing levels had been reduced to two care staff and one housekeeper during the day. The relief manager was available to help if needed during Monday to Friday daytime. As well as providing care and support, care staff were also responsible for administering medication and preparing, serving and assisting people with meals.

The provider told us that there was no staffing analysis or dependency assessments in use. They based the staffing levels on feedback from staff and the number of people residing at the home. Of the nine-people living at the home, two required the support of two staff members at times. One staff member told us there were not always enough staff on duty.

Records showed that most accidents at the home were unwitnessed. One accident report showed that the two staff on duty at the time of an accident were cooking and administering medicines. A fall sensor alerted them to a person mobilising who was at risk of falls. When the staff arrived, the person had already fallen.

We recommended that the provider reviewed the current staffing levels.

The home appeared clean to a acceptable standard. There were appropriately equipped hand washing facilities and hand sanitising gel was available around the home. The toilet frames that had become rusty and difficult to keep clean had been replaced with new frames.

Food was now being safely stored and appropriate food safety records were being kept. The kitchen areas were clean.

We also saw that overall there had been an improvement in the way people's finances were recorded. We asked the relief manager to ensure receipts were obtained and records were checked for accuracy and were possible a different staff member was involved checking these records.

There had been an improvement in how accidents and incidents were managed and saw that they had been reported and recorded appropriately. A monthly audit was completed and looked at when and how they had occurred, whether the response had been appropriate and if any patterns or trends could be identified. We saw that actions had been taken following an accident. For example, following a couple of falls one person was checked to see if they had an infection. They did and staff were able to obtain treatment and reduce the risk of further falls. Equipment was also put in place for some people in order to reduce risk of injury, such as sensors and crash mats.

There had been an improvement in the information available for staff on safeguarding vulnerable adults and how staff can report any concerns they may have. The relief manager made this information available and had personal refresher meetings with each staff member in relation to this. More staff had completed safeguarding training. Two thirds of staff had now completed this training.

Since our previous inspection PAT testing of portable electrical appliances for safety had taken place. Staff had received training in fire safety and people's personal emergency evacuation plans had been reviewed.

An appropriate fire alarm system was still in place; there was ongoing records of regular checks of the fire

alarm, emergency lighting and firefighting equipment. Records at the home now showed that staff had received fire safety training.

A legionella risk assessment was in place; during the inspection the relief manager was not able to show us the dates of the last legionella check. Shortly after our inspection the relief manager wrote to us and told us it was 19 November 2018.

People living at the home and one person's relative told us that they felt the home was safe and that the staff treat them well.

Inadequate

Is the service well-led?

Our findings

The home had a registered manager. The registered manager is also the nominated individual and the provider (a director of the company that owns the home). The registered manager had delegated the day to day running of the home to a full time 'relief manager'. The relief manager had been at the service since March 2018. The relief manager told us that they had been supported by the registered manager.

At our previous inspection there was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the provider had failed to maintain secure, accurate and complete records of the care provided to people. The disorder of information at the home meant that the registered manager or the relief manager could not assure themselves that people had received appropriate care.

At this inspection we saw that there had been an improvement in the records and documents being kept relating to people living at the home and their care. There was a new system in place to support people to deal with their mail and correspondence. There was now a system in place to support People with their healthcare needs and appointments. We saw evidence that this had resulted in an improvement in the support people received with their healthcare.

The confidential information of people living at the home and staff members was now kept securely.

During our previous inspection there was confusion over the format of people's care plans. Parts of some people's care plans were stored on an electronic system and other parts in paper files. Different staff told us that they updated different systems, meaning it was difficult to get the most up to date information.

At this inspection an electronic care plan and care note system was in use and people's daily care records and care files were kept electronically. Staff showed us how they made daily notes of people's support on an electronic tablet; they spoke positively about this and how it enabled them to make records of people's care closer to the time it happened.

The leadership at the home was still reactive. The registered manager and the systems in place were not yet ensuring that appropriate actions were being taken and necessary improvements were being made to ensure that the care and accommodation provided was safe and of high quality.

For example, the relief manager completed a weekly manager's walk around. However, this had not addressed trip hazards in the hallway carpet, along with trip and other safety hazards from exposed wiring in the upper stairlift. The checks had also not addressed the low wall light that had a sharp broken glass shade and exposed live electrical contacts; along with the unsafe storage of builders sharp electrical and hand tools. They had not addressed that the risk assessment in place for the refurbishment works was not being adhered to.

A Health and safety checklist completed in August 2018 had identified that the annual gas safety certificate

had expired. However, this had not prevented a 12-week gap of having no safety certificate in place before the boiler was identified as being, "immediately dangerous."

The previous annual gas safety certificate on file at the home was dated 12 January 2016; which indicates a previous 31-week gap. This indicates a pattern of the registered manager not keeping up to date with their legal requirements to complete essential safety checks on the gas supply and gas appliances at the home.

We checked the homes electrical safety certificate from December 2014. The usual recommended frequency for these checks is every five years. However, this certificate recommended that it was reviewed in 12 months. When this happens usually this is for a reason; however, we were not able to identify the reason as the last page of the document was missing. The registered manager was unable to tell us why this recommendation was made or if it had been considered; after our inspection the relief manager gave us feedback from the provider that, "The electrical safety had not been followed up in twelve months' time as this was only a recommendation."

Medication audits had improved; however, they had not addressed the poor stock control practices and the lack of medication guidance available for staff and not recording storage temperatures.

The home was using three staff members from another home like agency staff. Since our previous inspection the registered manager had still not assured themselves that the necessary checks as outlined in Schedule three of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014; and that the staff members had received appropriate training.

This is the fourth inspection where we have highlighted ongoing concerns with the oversight of and quality assurance systems within the home. Since January 2018 the home has been in special measures, during which time the registered manager had allowed areas of the home to be unsafe.

The registered manager had delegated the day to day running of the home to a relief manager who started working at the home in March 2018. However, it is the responsibility of the registered manager to ensure that systems and processes are in place at the home to ensure the equality and safety of the care and accommodation being provided. There was no evidence that the registered manager had any oversight of the systems in place at the home or completed any checks or audits to assure themselves that the systems in place were being effective.

This is a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During the previous two inspections we have informed the provider of their legal obligation to ensure that the Care Quality Commission (CQC) was informed of certain events affecting the health and wellbeing of people; along with events at the home that are likely to threaten the providers responsibility to carry on the regulated activity safely. This is by way of a statutory notification.

The provider had not informed us of the boiler being condemned and the gas supply to the home being capped ten days before this inspection started. It is clear in the Regulation that this is a reportable event; this shows a pattern of the provider not providing the CQC with information that they have a legal obligation to do so.

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

The manager told us they had learnt from past inspections and made some improvements in the home. We saw that during this inspection some audits had started to be effective and have a positive impact. A monthly audit was completed and looked at when and how they had occurred, whether the response had been appropriate and if any patterns or trends could be identified.

Also, a weekly kitchen safety audits had been effective with actions being identified and signed when completed. A weekly cleaning audit was now in place with actions identified being taken each month. An audit of the dining experience at the home had led to some significant improvements.

Since our previous inspection a copy of the home's complaints policy was available for people supported and visitors. It outlines who could be contacted at the home, including their roles at the home and their names. This also gave details of organisations people may wish to approach such as the local authority safeguarding team and the CQC.

Staff spoke highly of the relief manager and felt there had been a lot of improvements at the home. They told us that the staff and residents were happier, decorating had taken place and administration of people's medication had improved.

The relief manager told us they were continually using feedback from people and staff to help improve people's care. Staff members told us that they felt supported by the relief manager and that there had been improvements since they were in post.

Feedback had been sought from people's relative and visiting professionals. We saw that positive feedback had been received regarding the service. Relatives comments included, "[There has been] big improvement in the last six months." and, "New manager has improved the service, it's more homely." One person's relative told us, "[Relief manager] has been the best. They know what they are doing. Got any problems you can go to [relief manager], they sort them immediately."