Regal Healthcare Properties Limited

Oaklands

Inspection report

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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

About the service:
Oaklands provides accommodation and personal care for up to 53 older people, some of whom were living with dementia. At the time of our visit 41 people were using the service.

What life is like for people using this service:

We carried out this inspection in response to concerns about people's health, safety and welfare. At this visit we identified shortfalls that placed people at risk of harm.

Medicines were not managed and administered safely. Where people were frequently asleep at the time of the medicines round, attempts were not always made to administer the medicines at a different time. Where people had missed their medicines for more than three consecutive days, the service had not always raised this with their GP to check whether there would be any adverse effects on their health.

Risks to people were not consistently identified, monitored and managed. For example, care plans did not contain sufficient information for staff to provide care to people. Instances where staff had not followed care plans were not identified and acted upon by the service. A healthcare professional raised concerns with us about the pressure care provided to people.

The quality assurance system in place to monitor the service provided to people had not consistently identified all the shortfalls we found at the inspection. Lessons had not been learned from a previous incident. This meant that action had not been taken to protect people from the risk of potential harm.

People who live at Oaklands have their needs met by sufficient numbers of staff. The service was clean and appropriate infection control procedures were in place.

Following our inspection, we wrote to the service asking them to provide us with information about how they would promptly address our concerns and protect people from harm. They provided information that assured us sufficient measures were in place to protect people whilst improvements could be made.

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

Rating at last inspection (and update):
At the last inspection the service was rated Good. (Report published 26 October 2018)

Why we inspected:
The inspection was prompted in part by notification of a specific incident. Following which a person died after moving from Oaklands to another care home. This incident is subject to a criminal investigation. As a result, this inspection did not examine the circumstances of the incident.

The information CQC received about the incident indicated concerns about how the service managed and minimised the risk of people developing a pressure ulcer. This inspection examined those risks.

In addition to the above, we received concerns in relation to the care provided to keep people safe and in relation to safe medicines administration. As a result, we undertook a focused inspection to review the Key Questions of Safe and Well-led only.

We reviewed the information we held about the service. No areas of concern were identified in the other Key Questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those Key Questions were used in calculating the overall rating at this inspection.
The overall rating for the service has changed. This is based on the findings at this inspection.

We found evidence during this inspection that supported the concerns raised with us prior to inspection. Please see the Safe and Well-Led sections of this full report.

Follow up:
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 of 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?

Inadequate

The service was not safe.

Details are in our Safe findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our Well-Led findings below.

Oaklands

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. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Act, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Inspection team
This inspection was carried out by two inspectors.

Service and service type
Oaklands is a care home for older people, some of whom were living with dementia. People in care homes receive accommodation and nursing or personal care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a manager in place who was in the process of registering with the Care Quality Commission. Once they are registered, they and the provider will be legally responsible for how the service is run and for the quality and safety of the care provided in line with the Health and Social Care Act 2008 and associated Regulations.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. This included details about incidents the provider must notify us about. We used all this information to plan our inspection.

During the inspection
We spoke with four people who used the service and one relative to ask about their experience of the care provided.

We spoke with the operations manager, the manager, the deputy manager and three care staff. We looked at six records in relation to people who used the service. We also looked at staff files and records relating to the management of the service, recruitment, policies and systems for monitoring quality.

Inadequate

Is the service safe?

Our findings

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

At the last inspection the service was rated 'good' in this key question. At this inspection we found shortfalls which compromised people's safety and welfare. The rating in this key question is now 'inadequate'.

This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management
• Where the service had identified risks to people, such as the risk of them developing pressure ulcers, sufficiently detailed care plans were not in place to guide staff on the care the person required to reduce this risk.
• Four of the six people whose care plans we reviewed were at high risk of developing a pressure ulcer. Clear guidance was not in place for staff to include information about repositioning, appropriate skin care and other actions they needed to take to reduce this risk.
• We were told one person returned from hospital with a pressure ulcer. However, records kept by the service indicated the person acquired the ulcer once back from hospital. Records said they had a red area on one day and then six days later it was recorded as having progressed to a pressure ulcer. This person was in poor body condition at the time of inspection and their lack of nutrition put them at higher risk of rapid skin breakdown. Despite this, no sufficient plan of care was in place to advise staff on repositioning to reduce the pressure. Staff told us that there were no charts in place and they had not been repositioning the person routinely. The deputy manager confirmed no repositioning charts had been put in place until the day of our visit, when a doctor had visited the person.
• In the case of another person, their care plan did state staff should ensure they were wearing pressure relieving footwear. We were told at the inspection that the person had developed a pressure ulcer on their foot because staff had been putting slippers on them instead of the special footwear. Despite the manager telling us they had reiterated to staff the importance of wearing the pressure relieving footwear, we observed on two occasions during our inspection that the person was wearing normal footwear. None of the staff attending to them recognised this and took action. This put them at further risk of skin breakdown.
• Following the inspection, we spoke with a healthcare professional who told us they had concerns about the way the service managed pressure care. They stated that the staff did not follow advice given and that this led to some people developing pressure ulcers that may have been avoidable had proper care been provided. They said, "We are talking about basic care here."
• Concerns were raised specifically about the care of one person whose records we reviewed, which the professional felt had led to them developing a grade two pressure ulcer. Their care plan around skin integrity did not instruct staff on how to reduce the risk of their skin breaking down. However, an update in their medical care plan in December 2019 stated they required repositioning. Despite this, repositioning charts were not in place for this person.
• Following our inspection visit, a family member of one person contacted us with concerns about the pressure care that had been provided to their relative.
• The service had assessed people's risk of choking, but this did not always lead to clear care planning

advising staff on how to reduce the risk. Care planning which was in place, was not comprehensive enough and did not make clear all of the ways the risk could be reduced. For example, through proper positioning. There was also no information about what staff should do if someone choked. The service had a device to use in the event someone was choking, but during our visit this was on the top floor of the building which meant it could not be quickly accessed in the event of an emergency.
• One person was at risk of choking and had been placed on a modified texture diet and prescribed thickener to go in their drinks. Their care planning was conflicting, and in the 'care actions' part of their care plan it did not reflect their modified diet and thickener. In another part of their care plan it referred to them as having a 'normal diet' and in another place a 'fork mashable' diet which could cause confusion for staff. The persons care records state they had a choking episode on 22 December 2019, despite this in the 'must know' section on the electronic device care staff carry it did not state they had thickener in their drinks, nor did it accurately reflect the appropriate food texture they required.
• Where people had specific conditions such as diabetes type 1 or 2, there were no adequate care plans in place to advise staff on what support they required with this condition and to advise on signs of hypo/hyperglycaemia and what the acceptable blood sugar levels were for the person.
• Care planning in place for people who were at risk of falls or who fell regularly was not comprehensive enough and did not reflect all the ways the person could be supported to reduce this risk.

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

• Following our visit, we were so concerned about the risks to people that we wrote to the provider and asked for information about the actions they would take promptly to protect people from harm. Their response assured us that plans were in place to manage risks whilst improvements could be made.
• Despite our findings, people told us they felt safe living in the service.
• Risk assessments relating to the environment were in place. This included evacuation plans, these had been kept under review to ensure they remained accurate.
• Equipment such as fire detection systems, hoists and water quality were regularly tested for safety.

Using medicines safely
• Medicines were not managed and administered safely. Prior to the inspection, the manager informed us of a medicines error which had resulted in one person not receiving their prescribed night time medicines for 21 consecutive days. They told us this was as a result of them being asleep at the time of the night time medicines round, but that staff had not raised this with anyone to see if the medicines could be administered at a different time of day to ensure they had them.
• During our visit we compared the stocks of medicines against the medicines administration records (MARs) for some people using the service. Two of these people had not received prescribed medicines because they were recorded as being asleep.
• One person had missed their night time medicines on eight nights. The manager was not aware of this and it had not been raised with their GP to see if the medicines could be administered at another time of day or earlier in the evening.
• Another person did not receive their prescribed dietary supplement on five evenings. This person was prescribed this supplement because they were underweight and frail. The time was always recorded as being around 6:30pm, but staff had not made the manager aware of this or sought advice from the person's GP as to whether they could have it earlier in the day. We asked the manager to investigate this and following the inspection they advised that this person liked to go to bed early, but staff had not considered this when planning the medicines round.
• One other person had missed their medicines on four occasions because they refused it. There was no evidence to demonstrate staff attempted administration at another time. Staff had not made the manager

aware, nor had they contacted the persons GP for advice. We asked the manager to investigate this and following the inspection they confirmed that the person tended to refuse their medicines in the evening but was happier to take them earlier in the day. As a result, they contacted the persons GP to see if the time of administration could be changed to better suit the person.
• Overall, medicines administration was not person centred. People's preferred time of going to bed or getting up in the morning had not been considered when planning the times medicines could be administered.
• Despite the management team having been aware of the medicines error which they informed us of prior to the inspection, they had not identified the shortfalls we found during the inspection. This meant action was not taken until we informed them of the shortfalls.

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

Learning lessons when things go wrong
• Prior to our inspection concerns were raised about the care one person received at Oaklands before they died following a move to another care home. In particular, these concerns were around pressure care.
• The operations manager told us that management staff had carried out an investigation following this to identify whether any improvements to the service were required. However, this investigation report stated that there was a repositioning regime in place and it was being adhered to. This was not an accurate reflection of what the repositioning charts showed. This meant shortfalls in repositioning had not been identified and acted upon.
• Shortfalls in repositioning remained at our inspection and a monitoring system had not been implemented to identify when people were not repositioned appropriately. As a result, we were not assured that the service had learned from this incident.

This was a breach of Regulation 17: Good Governance of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• Systems and processes to safeguard people from the risk of abuse
At the start of the inspection the manager told us about changes they were making to the service to reduce a higher number of incidents where people physically assaulted other people. This included designating part of the building for people living with dementia and the other part for people who had a lower level of need.
• Despite having identified that there was a higher number of these incidents in the service, the care plans for some people who had assaulted others did not make clear what measures staff should take to reduce this risk. For example, in a list of incidents for one person it stated they had physically assaulted another person using the service. Despite this, it was not mentioned anywhere in their care plans.
• Care plans for supporting people who had behaviours staff may find challenging were not comprehensive enough and did not always include person centred information for staff on de-escalating the situation to protect the person and other people living in the service.
• Despite our concerns about care planning, staff were aware of the service's safeguarding policy and demonstrated a knowledge of safeguarding procedures. Staff had received training in this area.

Staffing and recruitment
• People told us they felt there were enough staff to meet their needs and this was confirmed by our observations.
• We observed staff were attentive to people and staff never walked past anyone without checking whether they could help them with something. Staff had time to spend with people, engaging them in conversation or keeping them company. This reduced the risk of social isolation.

• Most staff we spoke with told us they felt the staffing level was appropriate. Comments were made about there having been a lot of staff leaving and new staff starting. However, the operations manager told us that the aim of bringing in new staff was to improve the service provided to people.
• The service had robust procedures in place to ensure staff were suitable to work with vulnerable people. This included carrying out checks to ensure people did not have criminal convictions which may make them unsuitable to work with vulnerable people.

Preventing and controlling infection
• We observed that the service was hygienically clean and free from odours. One person said, "Nice and clean. Cleanliness is next to godliness."
• Audits were carried out of infection control to ensure the risk of the spread of infection was reduced.
• Staff had access to appropriate protective clothing (PPE) such as gloves and aprons to use when providing personal care to people or supporting with meals.

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 the last inspection the service was rated 'good' in this key question. At this inspection we found shortfalls in the quality assurance system which meant areas for improvement had not always been identified and acted upon. The service is now rated 'inadequate' in this key question.

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.

Planning and promoting person-centred, high-quality care and support; how the provider understands and acts on duty of candour responsibility; continuous learning and improving care and managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements;
• There was a quality assurance system in place whereby senior staff checked on the performance of the service and the completion of management audits. The most recent audit had been ineffective in independently identifying the shortfalls we found. This meant they had been unable to act on these and reduce the risk of potential harm.
• There was an improvement plan in place for the service. Issues around care planning were noted as an action, with a completion deadline of 30 September 2019. We identified shortfalls in care planning at this inspection, so this action had not been completed within the timescale set.
• A root cause analysis investigation had been completed following the death of a person who had been living in the service recently. Within this analysis it stated that a repositioning regime was in place, as advised by the district nursing team, and that this was being followed. This was not an accurate reflection of what the repositioning charts for this person showed. Had this been identified when the report was completed in September 2019, action could have been taken to implement monitoring systems to check whether staff were adhering to the repositioning regimes for other people. Following the inspection, the operations manager told us measures were now in place to ensure these were monitored.
• This root cause analysis investigation also found that staff displayed a lack of knowledge about pressure care and there were shortfalls in training. Further training was provided to staff in October 2019. However, the competency of staff with regard to pressure care had not been monitored. This meant that continuing shortfalls in the practice, knowledge and understanding of staff had not been acted upon appropriately.
• A new manager had been employed since October 2019 and was in the process of registering with the commission.
• The management team had failed to identify many of the shortfalls we identified at the inspection. They were aware that one person had developed a pressure ulcer because staff were not ensuring they were wearing their pressure relieving footwear. Despite this, they were not monitoring whether this continued, which is what we observed at the inspection.
• In addition, the management team had informed us of a shortfall in medicines administration which meant one person did not receive their medicine for 21 consecutive days. Despite this, they had not identified other people who were not receiving their medicines as prescribed. An improvement plan in place for the service

stated that medicines administration records should be audited daily to ensure compliance. However, the management team had not been doing this.
• We were told that team leaders were responsible for completing and updating people's care plans. However, the management team had not been checking that these duties were completed competently. This meant they failed to identify shortfalls in care planning which placed people at risk of potential harm.
• In addition, they had not been checking that staff were completing records such as repositioning charts appropriately. Whilst an audit in December 2019 identified some gaps in the repositioning charts for one person, no monitoring was carried out as a result of this. This meant they had not identified more gaps in charts which indicated people may not have received the care they required, putting them at risk of potential harm.
• There was a lack of accountability among the staff team and therefore no one took responsibility for ensuring that appropriate care was delivered. Many staff came into contact with one person who was supposed to be wearing pressure relieving boots. Despite this, none of the staff identified they did not have them on and corrected this. We observed a disconnect between senior staff who did not take an active role in leading by example. Care staff told us that senior staff did not participate actively in providing direct care and were unwilling to help out.

This was a breach of Regulation 17: Good Governance of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• Notifications and referrals were made where appropriate. Services are required to make notifications to the Commission when certain incidents occur.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
• A survey of the views of people using the service and their relatives had been carried out. The responses were mostly positive.
• People and their relatives were also invited to regular meetings where they could feedback their views and were asked for their opinions on subjects such as redecoration of the home and activities.
• Meetings were regularly held with staff at all levels. These were used to communicate areas for improvement and changes in ways of working.
• Staff made positive comments about the new manager and felt they could speak to them freely and give their feedback. One staff member said they felt the manager was trying to make staff more accountable, which they thought was positive.

Working in partnership with others
• A healthcare professional we spoke with following the inspection stated they felt the manager was not engaging and did not liaise with them when they visited.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment 1.Care and treatment must be provided in a safe way for service users. 2.Without limiting paragraph (1), the things which a registered person must do to comply with that paragraph include— a.assessing the risks to the health and safety of service users of receiving the care or treatment; b.doing all that is reasonably practicable to mitigate any such risks; c.ensuring that persons providing care or treatment to service users have the qualifications, competence, skills and experience to do so safely; f.where equipment or medicines are supplied by the service provider, ensuring that there are sufficient quantities of these to ensure the safety of service users and to meet their needs; g.the proper and safe management of medicines;

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance 1.Systems or processes must be established and operated effectively to ensure compliance with the requirements in this Part. 2.Without limiting paragraph (1), such systems or processes must enable the registered person, in particular, to— a.assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity (including the quality of the experience

of service users in receiving those services);
b.assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity;
c.maintain securely an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided;