Oasis Private Care Limited

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Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

This comprehensive inspection took place on the 12 June 2018 and 14 June 2018.

Oasis Private Care Ltd. is a Domiciliary Care Agency (DCA) who provide personal care to people with a variety of needs living in their own homes. At the time of inspection, the service was delivering personal care to 19 people.

There was a registered manager in post who was also the registered provider. 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.

At our inspection in September 2016 we found the service to be inadequate overall. As a result, the service was placed 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 provider's registration of the service, it will be inspected again within six months.

We returned to inspect the service in February 2017 and found the service had made some improvements. However, it was rated as requires improvement as we could not be assured the improvements made were sustainable.

At our last inspection in January 2018 we found the service had not sustained the improvements and were rated inadequate in safe and well led. At that time the service was not meeting the regulations related to safeguarding service users from abuse and improper treatment, safe care and treatment, good governance, fit and proper person employed, person-centred care and notification of other incidents. The service was rated as inadequate overall. This resulted in the service being put back into special measures.

At this inspection in June 2018 we found the service had not made the necessary improvements.

People were not kept safe because there were continuing issues with risk management at the service. Risk assessments did not always provide sufficient information to provide direction for staff, or information about how to reduce risks. This breached the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People did not always have their visits on time. The registered provider did not have an effective system in place to assess or monitor missed or late visits to ensure they are meeting the care needs of people who use the service and to improve the quality and safety of the services provided in the carrying on of the regulated activity. This breached the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Medicine records where inaccurate and didn't always include all medications currently prescribed for people. PRN (as required) medicines did not have any guidelines so staff did not have enough information on when or how to administer it. This breached the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered provider failed to inform others as appropriate about concerns or findings relating to a person's fitness. This breached the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's care plans did not have sufficient and personalised guidance to enable staff to identify and respond to people's needs and we could not be assured that people were always involved in the development of their care plans. This breached the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager failed to notify us of a reportable event in a reasonable timeframe. This breached the Regulation 18 of Care Quality Commission (Registration) Regulations 2009.

People told us that they were treated with dignity and respect.

There were sufficient staff to meet people's needs.

People told us they had their nutrition and hydration needs met. Staff told us they monitored people's nutrition and hydration.

People were happy with the care team that supported them.

Staff received an induction and ongoing training, to help them meet and understand the care needs of the people they supported. Staff said they felt supported in their roles.

The provider had not taken action following our last inspection and failed to identify and address concerns and breaches of regulatory requirements. This has led to risks to the quality of care and to people's health and wellbeing.

We identified four breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and one breach of the Regulation 18 of Care Quality Commission (Registration) Regulations 2009. Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations have been concluded.

The overall rating for this service remains 'inadequate' and the service remains 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 provider's registration of the service, will be inspected again within six months. The expectation is that 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 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 provider from operating this service. This will lead to cancelling their registration or to varying the terms of their 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.

Not all risks to people were assessed and mitigated. Guidance was not available to make sure all staff knew what action to take to keep people as safe as possible.

The provider failed to inform the appropriate body about concerns or findings relating to a person's fitness to work with vulnerable people.

Medication was not safely managed.

Is the service effective?

Requires Improvement

The service was not always effective.

Information about people's care needs was not always accurate or up to date.

Records did not always reflect that people were supported with hydration and nutritional needs in line with their care plan.

People received care and support from staff who had received the appropriate training.

Is the service caring?

Requires Improvement

The service was not always caring.

People we spoke we said that staff were friendly and caring.

People told us that they were treated with dignity and respect.

People were not always involved in the planning of their care.

Is the service responsive?

Inadequate

The service was not responsive.

People's care plans did not always have personalised guidance

to respond to people's needs.

People were not always involved in the development and review of their care plans.

People's care plans were not always updated to reflect their current support needs.

Is the service well-led?

Inadequate

The service was not well led.

The provider had not taken appropriate steps to ensure they had oversight and scrutiny to monitor and support the service. There were no systems in place to monitor and improve the service.

Care plans were not updated in a timely manner.

There was no process in place to allow the service to consistently learn, improve and innovate.

We had not always received information about certain events which had occurred at the service to enable us to monitor this.

Oasis Private Care Limited

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 checked 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 was a comprehensive inspection which took place on the 12 and 14 June 2018 and was announced. We gave the registered manager two days' notice of the start of the inspection because we wanted key people to be available and we needed to ensure someone would be at the office.
This inspection was conducted by one inspector, an inspection manager and one expert by experience (ExE). An expert by experience is someone who has personal experience of using or caring for someone who uses this type of care service.

We did not request a provider information return (PIR) because the inspection was a review of the service following the last inspection in January 2018 where the service was put in special measures. Before the inspection visit we looked at all the information we held about the service. This included the last inspection report and any notifications. Notifications are for certain changes, events and incidents affecting the service or the people who use it that providers are required to notify us about.

We received feedback from the local authority safeguarding team. We also requested feedback from five community health and social care professionals. We received one response.

During the inspection we spoke with the registered manager, the deputy manager and the care coordinator. As part of our inspection process we speak to as many staff members as possible. However, in this instance only four care staff members were available over a period of 9 days and provided an email response. We spoke with five people who use the service and five relatives of people who use the service. We looked at seven people care records, five staff recruitment files, induction and training records, quality assurance audits, accidents/incident records and medicine administration records.

Inadequate

Is the service safe?

Our findings

At our last inspection in January 2018, we found the service was not meeting the regulations related to safe care and treatment because risk assessments did not contain sufficient accurate and up to date information to provide guidance to staff. At this inspection we found this regulation was still not being met.

Although people and their relatives told us they felt safe, we continued to find that people were not always kept safe. Risk management within the service was poor. Risk management plans were not clear and not routinely followed. The service was not always identifying relevant risks and managing them appropriately to keep people safe from harm. Risk assessments should provide clear and person-specific guidance to staff and ensure that control measures are in place to manage the risks an individual may be exposed to. A health and social care professional told us that they had concerns about the management team's lack of understanding regarding risk and safeguarding.

The registered provider did not have effective systems in place to assess and manage the risks relating to the health, safety and welfare of people who use the service and others who may also be at risk. Where risk assessments identified a risk, records did not always reflect that appropriate management plans or control measure were in place. For example, a person's care records stated that an incident had occurred which put another health and social care professional at risk. The risk management plan informed staff to attend visits in twos, however did not identify why they must attend in twos and did not refer to the incident. The plan stated staff should report to the office if the person is "feeling low" and "carers to ensure that [name] understands them when [name] is low", and to "reassure" the person. There was no specific guidance for staff about how they should manage this risk for the person and no information on what triggers this behaviour that could potentially lead to a further incident. Failure to ensure effective systems and process were in place to mitigate risk was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Another person had a risk identified of suffering from a medical condition impacting their feet however there was no management plan or mitigation in place to reduce this risk. We noted however in the daily care notes of this person that a staff member had recorded that the GP advised the person should keep their feet elevated. This was not in the care plan or risk management plan. Another person had a risk identified that they bruise easily however there was no mitigation or control measures in place to minimise this risk. Lack of information and documentation meant that the provider was not able to assure themselves that risks in relation to people's health and safety were being mitigated. Due to the limited number of staff who were able to speak with us, we were unable obtain sufficient staff responses to assure ourselves that they understood the individual risks associated with peoples care and support needs.

Accidents and incidents were not consistently reviewed to look for patterns or to check that effective measures had been put into place to reduce the chance of them happening again. Investigations into incidents were not always carried out which meant that opportunities to learn from them were missed. There had been three incidents recorded since our last inspection. The provider had taken appropriate action, however, the investigation into the incident and the lessons learnt for the service had not been

recorded. We discussed this with the registered manager who advised that they were in process of developing a detailed system for recording accidents and incidents which would also prompt a full investigation and report where required.

The registered provider failed to ensure that they were doing all that is reasonably practicable to mitigate risks. This is a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our inspection in January 2018 we found that the service did not ensure proper and safe management of medicines. At our inspection in June 2018 we found that this had not improved.

People were not always kept safe and were at risk of receiving inappropriate care relating to their medicines because systems for recording information was inconsistent and inaccurate. The registered manager advised that the service kept both paper and online care records as they were currently introducing an electronic care records system. They told us that the most up to date information was kept on the electronic system and this is the information the staff used to deliver care. However, when we reviewed both the paper records and the electronic care records we found that neither reflected the most up to date care needs about the person. For example, one person's care plan had a list of medication that they are prescribed in their paper file which differed from their electronic file. Records did not reflect the current medication that the person was being prescribed, which included tablets, oral sprays, as well as prescribed creams. The person's electronic and paper records did contain a medicines administration record (MAR). The provider conducted further investigation during the inspection and obtained an up-to-date list of the person's medications. We were able to determine that both the paper file and the electronic file were inaccurate. Staff were unable to see the most relevant medication details. This put the person at risk of not receiving the correct medication at the time they needed it which could impact their health and the efficiency of the medication. The deputy manager updated the electronic system during the inspection to ensure it reflected the person's current prescribed medications.

Governance of medicines was not safe which meant that the provider could not assure themselves of the safe management of medicines. The electronic medicine administration record (MAR) charts often were not completed and the provider told us they used paper copies. However, the paper MAR did not detail each medicine taken from the monitored dosing system (MDS), only the number of tablets. The MDS groups all medicines that need to be taken at a certain time of day into one sealed packet so the person just takes all the tablets from the relevant packet. However, not all medicines can be included so there were several other prescribed tablets, powders or creams that also need to be accounted for. As medicines lists were not up to date or accurate, it was not always possible to determine from the records what medication a person was currently prescribed or when they needed to take it. For example, one person had a medicine list in their care records stating that they needed to take 16 tablets a day. There was nothing in the records to show which medicines were in the MDS and which needed to be administered from separate packaging. After further investigation and speaking with the staff member who was in the person's home we found that there was a total of four tablets a day unaccounted for that would need to be administered from separate packaging. However, neither the staff member, deputy manager or registered manager were able to confirm if the missing medicine was in fact being administered to the person or why there was no record. The explanation from the registered manager was that it was likely to be pain relief which had been changed to PRN (as required) and now administered by the person's family, however they were unable to confirm this at the time of inspection. There was no record of this in the care plan. This was followed up by the registered manager with the person's GP following our inspection and they found that the medication was PRN for pain relief. The registered provider failed to have robust processes to record and ensure a person's current medicines were accurate and up-to-date which meant that they could not assure themselves that the

correct medication was being given at the time it was needed.

PRN medicine is taken when needed. The service did not have protocols or guidance in place to ensure that people always received their PRN medicine appropriately. For example, in the plan for a person prescribed a PRN medicine, there were no guidelines regarding when this medicine might be required. There was no guidance advising staff about when to administer the medicine or if the person was able to identify for themselves when they needed the medicine. There was no information to support staff to look for particular signs and symptoms to ascertain if the medication should be given. This meant it was not clear from the care plan that the person was always being given their PRN medicines safely and in line with pharmaceutical guidance. This could compromise people's health and well-being.

The complexity of some people's needs with regard to their medicines and a lack of clear information did not assure us that staff would always be able to provide safe management of medicines, this put people using the service at risk of harm.

We also reviewed a person's care records who was prescribed a barrier cream to prevent skin breakdown. However, the care records did not clearly reflect that staff members should be administering this during their visits. The provider did not have a MAR chart for this prescribed medication. When we asked the registered manager why this prescribed cream was not on the care records as an action that should be completed, they advised that it should be and added it to the care records during the inspection. When we asked the registered manager why they did not have a MAR chart for this prescribed medication, the registered manager said, "because it's just a cream". This response did not assure us the registered manager understood prescribed creams are medicines and should be treated as such. It was not clear from the records that this person received their medication as prescribed. This meant there was potential for the person to suffer from an uncomfortable and painful skin breakdown The National Institute of Clinical Excellence (NICE) states that Social care providers should have robust processes for care workers who are supporting people to take their medicines. This includes how to give specific formulations of medicines, for example, patches, creams, inhalers, eye drops and liquids. The provider failed to follow national guidance in relation to managing medicines.

We reviewed this person's daily records and found that from the 09 May 2018 to 13 May 2018 on five occasions the person had reported to staff or staff had observed that the person was in continued discomfort on a specific area of their body. Staff recorded that they had applied cream to this area. However, there was no evidence that staff had reported the person's pain and discomfort to a health professional. Consequently, the person had reported it to their own GP. Nine days after the initial concern was identified, a district nurse attended the person in their home and staff recorded that "he had a pressure sore" in the same area of their body that they had previously reported discomfort and "the nurse came to dress [it]". The registered manager was unable to confirm that they had contacted a health professional.

Information about people's medicines was not recorded accurately. Medicines were not managed in a way which ensured people received them in a safe and effective manner with regard to the risks associated with them. Staff did not always act on concerns relating to people's health and wellbeing which put them at risk of harm. This constituted in a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Safe care and treatment.

At our inspection in January 2018 we found that the service did not have robust process to ensure fit and proper persons were employed. At our inspection in June 2018 we found that this had not improved sufficiently.

The provider did not always follow the correct processes to keep people safe. For example, a staff member was involved in an incident which took place in April 2018 that put a person receiving care at risk. The registered manager took the appropriate action by referring to the local authority safeguarding team and ensuring that person had support for their remaining calls. Although there was no record, the provider told us an investigation of the incident was completed which resulted in the staff member being dismissed. However, the provider failed to make a referral to the disclosure and barring service (DBS) despite having a legal duty and being informed by the local authority that this is something they should do. A referral is information about a person where there are concerns that an individual may have harmed a vulnerable adult, or put them at risk of harm. When we asked the provider why this had not been done they informed us they were awaiting legal advice. The provider has a legal responsibility to make a referral to the DBS as they decided to dismiss the person or remove them from working in regulated activity. We discussed this with the registered manager during the inspection and advised them they have a legal duty to inform the DBS. The registered manager made a referral to the DBS following our inspection.

The registered provider failed to inform others as appropriate about concerns or findings relating to a person's fitness. This is a breach of regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service had a whistleblowing policy and staff received training in whistleblowing awareness. Staff told us they would be happy to use the policy. One staff member told us, "I like it because you can report something without saying your name".

There were sufficient numbers of staff to meet people's needs. The care coordinator informed us that they complete and send a to people who receive care once week in advance. They use an electronic system to allocate staff members to visits based on their availability. They informed us that they let staff swap shifts amongst themselves and then they would bring this information together and create a final rota to send out. People and staff confirmed that there were sufficient staff to their meet needs.
Training records showed staff had received training in safeguarding vulnerable adults. One staff member told us, "You should then report your concerns and what you've been told to someone with responsibility for safeguarding". Staff we spoke with could give examples of the different types of abuse people may face and what action to take if they suspected abuse was taking place.

People and their relatives told us that they felt safe. One person told us, "They're normally very good, all friendly and I feel safe with them". A relative told us, "Yes, everything is safe now, it was just in the initial weeks things were not, while things were settling down".

The provider had suitable procedures for preventing the spread of infection. Staff completed training in relation to infection control. The registered manager told us that the care workers were provided with personal protective equipment including gloves to use when providing support. One person told us, "Occasionally a manager comes around, usually to top up supplies of gloves and bits and pieces".

Requires Improvement

Is the service effective?

Our findings

People's care needs were assessed to identify the support they require. However, information about people's care needs was not always accurate or up to date. For example, one person's record stated that they needed assistance with mobilising and that they could not walk independently. Another section of the care record said they could walk independently. We asked the registered manager why the care needs were conflicting and they advised that the person could mobilise independently and the care records were inaccurate. Another person's care record stated they needed support with showering, however another section of the care plan when asking what support is needed with showering said "NA"' (not applicable). The registered manager said this person could shower themselves however staff were available in the event they need support and that this was a recording error. Where care and support needs had been identified, records did not always contain the detail required to meet these needs. For example, one person's care file stated they needed assistance when transferring however there was no guidance or detail on how staff need to do this. The registered manager informed us that these people were able to speak for themselves and assured us that their needs were being met. The registered manager acknowledged that the records were not up to date and accurate in relation to people's care. Areas identified of concern relating to accurate, complete and contemporaneous records are dealt with in the well led domain.

People received care and support from staff who had received the appropriate training. All staff had recently been fully trained in the all areas considered by the provider to be mandatory. One person who uses the service told us, "They are all trained up". Another person told us, "They all know what they are doing as far as I am concerned".

Staff told us they received supervisions where they could discuss any concerns and development needs, these were recorded and kept on file. Where staff were supporting people with particular needs such as epilepsy, care with medical equipment and support with mobility using a hoist, specific training had been sought from the relevant professionals. Staff had been assessed as competent by these professionals. The care co-ordinator managed a matrix which identified when staff had been trained and when the refresher training was due.

Performance and competence of staff was monitored by way of spot checks. The management would complete overall spot checks and observe staff undertake their duties with people during a care visit.

Staff told us they received annual appraisals however records did not always reflect that these had taken place. For example, one staff member's records showed that they had their last appraisal in 2014. When we asked the registered manager to clarify they were unable to provide evidence that regular appraisals had taken place but agreed to ensure they had a better system in place to monitor appraisals.

Records did not always reflect that people were supported with hydration and nutritional needs in line with their care plan. Staff were not always documenting whether food and drink had been provided. We spoke with the registered manager and they informed us that staff had supported people with meal preparation in line with their care plan, however they may not have recorded the information correctly on the system. One

staff member told us that, "A record of food and fluid intake daily is done on the daily logs and action is taken where necessary". People who use the service, and their relatives, were happy with the way staff supported them with their nutrition. The provider confirmed that the people they supported at the time of inspection did not require any specialised support with their eating and drinking. Staff worked with the speech and language therapist when appropriate to ensure that where there were concerns about how a person ate or drank that these needs were properly assessed.

Records showed that management worked with other organisations in order to deliver appropriate care. For example, we saw communications between the GP and the service for one person with a significant and fluctuating health condition. We saw in one instance an occupational therapist had been involved due to a person's bed impacting on their personal care regime. This had resulted in the purchase of a specialist bed to enable them to transfer more effectively and receive personal care. However, as referenced previously in the report we had concerns that health care professionals were not consistently involved in peoples care and support. In addition, information about people's current and past healthcare conditions was not clearly recorded in their care plans (when necessary). This meant that staff, especially new staff, may not have a complete understanding of people's healthcare needs which may create potential risk for people. We discussed this with the registered manager who acknowledged that care plans were not sufficiently detailed, this is discussed further in the well led domain.

The staff we spoke had an understanding of the Mental Capacity Act 2005 (MCA) and told us they always look to asking people for consent prior to delivering care. A health and social care professional told us about a person receiving care from the service that, "they would always consult him on his preferences on how he wanted to be supported". One staff member said they, "Expressly ask for [people's]consent".

The 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 Act 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. In the community people can only be deprived of liberties if agreed by the Court of Protection. No actions had been taken, to date, with regard to making applications to the Court of Protection to restrict people's liberties.

Requires Improvement

Is the service caring?

Our findings

We considered whether people had been involved in decisions about their care. Care plans we looked out didn't always contain sufficient detail regarding people needs and preferences. People told us they were not involved in developing their care plans. One person told us, "No, there is nothing formal in place to set up a review as far as I know". Another person said, "No, I haven't had a formal review of my care plan for some time". We asked relatives if the care plan had been reviewed with them. A relative told us, "Well I think the care plan review only ever happens [when] we initiate things". Another relative said, "There hasn't been any formal reviews of the care plan agreement with Oasis". Care plan records did not always reflect that the person or their family, if appropriate, had been involved in the development of the plan and were not signed. We asked the registered manager how they involve people in their care plans and they told us they will leave a copy in the home for the person and family to read to ensure they are happy with it. The registered manager acknowledged that care plans were not always sufficiently detailed. However, they told us that staff understood people's needs and preferences. We were unable to speak to a range of staff to be assured they understood people's needs and preferences.

The registered provider did not always involve people in an assessment of their needs and preferences. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they felt that they were treated with kindness, respect and compassion. One person told us, "No problems at all, they are all great". Another person told us, "[Name] is a great carer". A family told us about their relative receiving care, they said, "He is content and happy with them, they are very attentive". Another family member said, "The levels of care have been good in our estimation".

People were happy with the care team that supported them. Some people enjoyed a mix of different care staff and others enjoyed a stable staff team. We received comments from people such as, "The carers are really great, there have been two new ones recently, a lot younger and they are very respectful", "There are always different carers but it doesn't worry me" and "They're all good and I get lots of different ones". However, one person told us, "Generally I get the same carers". Another relative told us, "We have a continuity of carers".

People's privacy and dignity was respected. Information about people was written respectfully. One relative told us, "The carers are definitely conscious of [her] dignity; they recognize her privacy and ensure windows are closed and curtains drawn at appropriate times". A staff member told us that they ensure they handle personal care, "Hygiene activities sensitively".

People were supported to be independent. One staff member told us about the people they support, that they, "Respect their right to make choices" and that they "encourage [people] to do things for themselves". A health and social care professional told us that a, "Client had regained some independence in some of his day to day living activities" following receiving support from the service.

Inadequate

Is the service responsive?

Our findings

People's care plans had information that identified their care needs. However, records were not always accurate or sufficiently detailed to enable staff to respond to people's needs in a personalised and responsive way. For example, one person suffered from a lifelong condition that needed to be managed through medication and monitored closely on a daily basis, which the person was responsible for doing themself. However, they were not always happy to do so which put them at risk. The service had informed the GP of these concerns.

Although this person was responsible for monitoring their own health, the person's care plan stated that care staff should call a GP when the daily monitoring tests results were higher than stated in the care plan. We reviewed this person's daily logs that staff complete following a visit. On nine occasions over a period of seven days, staff had recorded that monitoring had identified a result higher than the care plan stated was safe, on one occasion the person also reported feeling unwell. It was not clear that staff had identified this as a problem or that the GP had been contacted in response to the results. We spoke with the registered and deputy manager who explained that the specific part of the care plan was generic rather than personal, despite being labelled for the person. We asked what level an unsafe test result should be for the person which triggered the service to take action, but they were unable to tell us. It was not clear this person was receiving care and treatment that was personalised to their needs. The service did not know at what point their results indicated that their condition was not being managed or under control and the person was at risk. Furthermore, there was no personalised guidance for staff on what to look for in the person's behaviour should their health be deteriorating. As a result of our intervention the provider contacted the GP during inspection to ensure they had the correct information to support this person safely.

People's care plans were not sufficiently detailed or clear to ensure their individual needs would be met. For example, one person was prone to urinary tract infections (UTI) however the care plan did not detail how this person may present if they are suffering from a UTI or how staff must respond. Records did not reflect how this person would present, therefore the provider could not assure themselves that they would be able to identify risk. This meant the person may not receive a timely and person-centred response to their care needs.

This above constitutes a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was some information about people's communication methods which demonstrated that the provider was aware of the requirements under the Accessible Information Standard (AIS). AIS is a framework put in place from August 2016 making it a legal requirement for all providers to ensure people with a disability or sensory loss can access and understand information. The registered manager told us there was currently no one who required specialist communication methods but that they would be able to meet these needs, if required. A staff member told us that if someone had communication difficulties they, "Use communication aids such as writing down, using pictures, signs and gestures".

People's complaints were listened to and acted upon. Since our last inspection there had been four complaints. Three of these were regarding personal belongings that been broken by staff members. The fourth complaint was regarding the conduct of a member of staff. Each complaint had been responded to and resolved to the satisfaction of the complainant. However, the management team had failed to record the investigation that had led to the resolution of the complaint. This meant there was no way of identifying themes, trends or lessons learnt from the outcome of the complaint investigations that would enable actions to be put in place to prevent reoccurrence. On speaking with the registered manager about the staff conduct it was clear that an investigation had been completed to resolve the issue and prevent future complaints however this had not been recorded.

Inadequate

Is the service well-led?

Our findings

People didn't always benefit from a well-led service.

We asked people and their relatives if the service was well-led and we received a mixed response. One relative told us, "I think the only area where Oasis struggle is with corporate communication". They went on to say, "We rely on direct contact with carers and there is no handover [from] management". Another relative said, "Well we don't see or have contact with management often, but we did meet them at the beginning of our arrangement". Another relative said about the manager, "We have a good relationship with her".

At our last inspection in January 2018, we found that the provider did not have effective systems in place to ensure they had oversight of the quality of the service being delivered to ensure they were keeping people safe. At our inspection in June 2018, we found that people were not protected against the risks of inappropriate or unsafe care because records were inaccurate. The provider did not have effective systems in place to monitor and improve the quality and safety of the service being provided.

The service lacked an effective governance framework. There was no clear delegation of responsibility and not all regulatory requirements were understood. While the registered manager was aware of the need to conduct audits, they were sparse and inconsistent. They did not have a comprehensive system to assess, monitor and improve the quality of the service. They did not have an effective system to assess, monitor and mitigate risks to people using the service or others including staff working in the service.

At this inspection, we found the provider had introduced some quality assurance audits however these were not effective and they had failed to identify errors and breaches of the provider's own policies and procedures. For example, one audit completed in April 2018 of a person's daily records stated that there were "no deviations from the care plan". However, when we reviewed the daily records for April 2018 they showed that on a number of occasions the staff members should have been contacting the GP as stated in the guidance in the care plan. There was no evidence in the records this had been done. The audit had not identified that care staff had not followed the care plan or noted that this was a concern.

Medication audits had been completed quarterly for people who receive medications. We reviewed people's care records in line with the audit which had been completed and we found that these audits did not reflect the medication errors which had occurred. For example, an audit had been completed in May 2018 for a person who receives support with their medication, this audit found no concerns and reported that all medication recording was correct. However, we identified errors in the medicines records for this file throughout the month of May 2018.

At our inspection in January 2018 we saw that the provider had recruitment procedures in place however these were not always followed. At this inspection, only one staff member had been recruited since the last inspection and relevant checks had been completed. However, the registered manager was not clear about how to meet the regulations of the Health and Social Care Act relating to recruitment. We arranged for the provider to have a copy of Schedule 3 and a link to the provider guidance during the inspection.

The provider did not have effective systems in place to monitor feedback from people. The provider had sent a quarterly quality survey. People using the service and their families were contacted regularly to gain their feedback about the service. The management team kept files of the responses and what that said about their service. The responses we saw over the past year were positive with some people saying they felt the service was excellent and that they would recommend it to others. Where there were negative comments or concerns reported, the management told us they would address each comment if there was sufficient detail. There had been three concerns reported from people using the service. One highlighted that staff time keeping was unreliable. The second was a request that the care manager should go through the care plan details with people and the third was that people would find it helpful if the same staff members came rather than new ones. We asked the provider to show us the records of how these comments had been addressed however they advised these were not recorded. They could not tell us what they had done to address these concerns. Therefore, the provider was unable to identify trends, themes and lessons learnt to improve the service.

There was no process in place to allow the service to consistently learn, improve and innovate. Poor record keeping meant that events with positive or negative outcomes were not routinely recorded and reviewed. There was no system allowing management to be proactive in analysing incidents and identifying trends and themes. As such, when individual concerns were dealt with and addressed it was not clear what actions were taken to prevent reoccurrence.

Where people's needs changed, the care plans were not always updated in a timely manner. For example, one file recorded that a person was at high risk of skin and tissue damage and had a pressure ulcer which had developed in November 2017. The management team told us that the district nurse had been treating this and it has since healed. This had not been recorded in the person's care plan. The records did not demonstrate that the service had reviewed this person care to ensure that the plans were being met and were still relevant.

The provider was unable to demonstrate that the service people received was adequately reviewed by them, nor that it had continuously improved. An external consultant had been employed to complete an audit of the service in line with the CQC key lines of enquiry and to identify areas for improvement. The consultant had conducted their visits on 24 April 2018 and 01 June 2018. They had identified areas of improvement which were related to our inspection in January 2018. However, at this inspection we found continued concern.

There was not an effective system in place to ensure calls were on time. At our inspection in January 2018 we saw that the provider did not have robust systems in place to monitor missed or late calls and ensure people were receiving care on time. At this inspection, the service still did not have an oversight of missed or late calls. We asked the management team what measures were in place to prevent calls being missed or late. They advised that people whose care is funded by the local authority have an electronic system that states the time the visit should be and where staff must record what time they arrive and what time they leave. We looked at this system during the inspection and we noted that one person was expected to have their morning care visit at 8am, however the staff member had arrived over 1 hour later. The registered manager advised that this person prefers a later call. However, this was not in the care plan and care records did not reflect that this person prefers a later morning call.

For people who privately fund their own care, they told us staff would ring the office if they were going to be late for a call. We asked if these calls were recorded anywhere however we were told they had not been kept. They advised they would expect the person or their family to call if the staff member did not turn up or if they were late by 30 minutes or more.

People using the service and their relatives told us that care workers did not always arrive on time, although people did not report this an issue. Some of the comments we received included, "Their timing is a bit random but that is not a problem for me", "they are supposed to be here for 45 minutes, probably they stay for 30 minutes but we have an agreement to be flexible within certain boundaries" and "It is not necessary for them to come at precise times so they come when they are ready to". A health and social care professional told us they had received a number of calls from various people regarding late or missed calls.

The registered manager said they were unable to monitor late or missed visits for all people who receive care from the service. There was not an effective system in place to monitor late or missed calls and therefore, the register manager had no oversight of the impact that this might have. People were at risk of harm as it was not clear whether people who required time critical care received it in line with their assessed needs.

The provider did not have effective quality assurance measures relating to medicine management, risk management, care plan reviews, late and missed calls and monitoring of nutrition and hydration. The registered provider had failed to identify these risks through their own quality assurance measures. The constituted in a continued repeated breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the last inspection in January 2018, we found that the registered manager of the service had not always notified CQC of a reportable event within a reasonable time frame. At our inspection in June 2018, we found that the registered manager continued not to comply with this requirement. For example, a safeguarding incident which took place on the 19 February 2018 was reported to CQC on 15 March 2018. When we asked the registered manager why there was a delay in reporting they demonstrated they were aware of their responsibilities with regard to reporting significant events to the Care Quality Commission; however, could not provide a satisfactory explanation why this had not been completed 'without delay'. This meant we could not check that appropriate action had been taken to ensure people were safe.

The registered person failed notify the Commission without delay. This is a continued breach of Regulation 18 of Care Quality Commission (Registration) Regulations 2009.

The provider is required by law to visibly display their CQC rating at their premises. We found that the current rating was displayed clearly at the time of inspection.