Oregon Care Limited

Redstone House

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: Redstone House is a small home for people with learning disabilities that was providing personal and nursing care to four people at the time of the inspection.

People's experience of using this service:
● Staff understanding of risk management was not sufficient to ensure people were kept safe. Staff had still not recognised or reported incidents and accidents to the appropriate authorities.
● Staff had not understood that restricting someone's activities in response to that person's behaviour was a form of institutional abuse. Two instances of one person hitting another had also not been identified as potential abuse. None of these had been notified to the relevant authorities.
● Concerns over how people's monies were managed had also been raised. Purchase of take away meals and payment of activities had been done with people's monies. These costs should have been already included in the care package paid for by the commissioners of the service, and not needed people to pay for them themselves.
● Guidance documents for staff to keep people safe were not adequate to minimise the risk of harm. This included staff understanding of how to respond to behaviour that may challenge, and night time fire evacuation arrangements.
● Staffing levels had increased, however people's activities were still impacted by a lack of staff. Staff were working long hours to cover shifts, leaving them at risk of being tired and increasing the chance of mistakes being made.
● Further work was needed to ensure peoples medicines were managed and administered in a safe way.
● The registered manager had left the home since our inspection in December 2018. The home was being managed by two registered managers from the owner's other homes.
● Some improvements had been made, and further improvements were planned, however there were still many areas identified at the previous inspection that had still not been taken care of.
● The management structure of the service was fragmented and confusing to the staff. Key information and support were not available to staff when they needed it. For example, documents around finances were not available at or after the inspection because the person in charge of these was unavailable. No contingency was in place for other people to be able to access the information in their absence.

Rating at last inspection:
● At our last inspection in December 2018 (report published February 2019) we rated the service as inadequate. At this focussed inspection we saw that some improvements had been made, and the process was ongoing, the overall rating remains the same.

Why we inspected:
● This focussed inspection took place as we had received concerns around the care and welfare of the people who lived here.

Follow up:
● We will continue to monitor the service to ensure that people receive safe, compassionate, high quality care. Further inspections will be planned for future dates.

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

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.

Redstone House

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.

● The inspection was prompted in part by notifications by the local authority safeguarding team that people were still at risk from not receiving care that met their needs.

Inspection team:

● Our inspection was completed by two inspectors.

Service and service type:

● Redstone House is a 'care home'. People in this care home receive accommodation and personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

● Redstone House accommodates four people in one adapted building.

● The service had a manager registered with the Care Quality Commission, however they had recently resigned from their job at the home. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection:

● Our inspection was unannounced and took place on 4 March 2019.

What we did:

● Before the inspection we reviewed information we already held about the service including notifications that the service sent us. We also checked for feedback we received from members of the public, local

authorities and social service commissioning groups. We checked records held by Companies House.

● We had not asked the service to complete a Provider Information Return (PIR) s this inspection was responding to concerns. The PIR is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

● During the inspection we spoke and interacted with the four people who live here. We spoke with five staff, which included the two managers who were in place as a result of resignation of the registered manager.

We looked at the following records:
•□Four care plans and associated daily notes of care given.
•□Medicine administration records for four people
•□Records of accidents, incidents and complaints
•□Audits and quality assurance reports
•□We requested additional information to be sent to us after our inspection that related to management of people's finances, and staff meeting minutes.

Inadequate

Is the service safe?

Our findings

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

People were not safe and were at risk of avoidable harm. Some regulations were not met.

● At our previous inspection in December 2018 we rated this domain as Inadequate. This was due to failures across the domain. This included failure to follow local authority safeguarding protocols when abuse was suspected; failure to notify the CQC of significant incidents; lack of effective risk assessments; concerns with how peoples medicines were managed; and people not receiving the care they needed to manage their behaviours.
● At this inspection, although some improvements had begun, we identified that the concerns had not yet been fully addressed by the provider.

Systems and processes to safeguard people from the risk of abuse
● People were still not adequately protected from the risks of abuse.
● Incidents had taken place which had not been recognised as abuse, for example after a person had displayed behaviour that challenged, staff had cancelled an activity for that person due to 'inappropriate behaviour.' This is institutional abuse.
● When we brought this incident to the attention of the manager their response was, "I'm mortified that they did this." They assured us that they would consider this and complete the necessary referral to the local authority safeguarding team.
● Two incidents where one person hit another (no injuries were sustained) had also not been recognised by staff as potential physical abuse. As such these had also not been referred to the local authority safeguarding team.
● The management of people's monies left them open to the risk of financial abuse. Staff made decisions on what people's money was spent on. This resulted in people's money being used to purchase take away meals, or trips out. These costs had already been paid for within the package of care by commissioned by the relevant social service authorities.

Failure to identify and report safeguarding incidents was a continued breach in Regulation 13 (Safeguarding people from abuse and improper treatment) of the of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management
● Assessments had been completed to minimise the risk of people coming to harm. However, these were not effective at helping staff to support people to overcome their specific behaviours.
● For example, behaviour guidelines for 'Grabbing cups and glasses' recorded that staff should intervene when the person grabs a cup or glass; Staff to sign to the person to put it down; staff to sign that this is not acceptable; and staff to redirect the person.
● When a person tried to take a cup from an inspector staff did not follow these guidelines. One staff

shouted out and was unsure of how to deal with the situation. It took another staff member to call out for the person's own yellow cup which then de-escalated the incident. The noise and disruption due to staff not managing the situation caused another person to make themselves sick.

● Staffs lack of understanding on why people did what they did was still in evidence, as identified at our last inspection. When we spoke with staff about an incident of one person hitting another they said, "I don't know why [the person] does it. No blood has been spilt though." Lack of understanding and clear guidelines for staff meant that risks of harm to people were still not well managed.

● Peoples safety at night had also not been fully reviewed with regards to fire evacuation. Staffing levels at night were one waking night staff. No recent night time evacuation had been completed to test that one staff member would be able to support all four people to safely evacuated the building.

● The last day time fire evacuation drill had identified an issue with one person refusing to leave the house. The impact of this happening at night, with only one member of staff present, and how it may affect other people evacuating the house had not yet been addressed by the provider.

● Personal emergency evacuation plans (PEEPs) were still under development. This is a document that identifies what support each person would need at night should the building need to be evacuated. Until this was completed and tested there was an ongoing risk of people not being supported in a safe way should they need to evacuate the building at night.

Using medicines safely

● Medicines management had some improvements since our last inspection, however further work was needed to ensure safe working practices.

● Medicine administration records (MARs) information did not always match the detail in people's care records. For example, medicine was listed on each person's 'medical profile' which was not always listed on the MAR. The manager said they were still working through documentation making improvements. The MAR's were correct, and it was the 'medical profiles that needed to be updated. The manager modified the documents by hand at the time of the inspection so the information was now correct.

● Medicine administration records (MARs) were completed when medicines had been given, and details about what the medicine was for. Guidelines for 'as required medicines' such as pain relief were also seen to be included on the MARS. This detailed how often they could be given over a period. This minimised the risk of overdose.

Learning lessons when things go wrong

● The staff continued to record accidents and incidents at the home, however work to analyse these to prevent reoccurrence was still in development.

● Care staff had begun to liaise with the community learning disability behaviour team to understand people's behaviours. However, this had only just begun and analysis of incidents was not yet taking place.

● Where staff had completed behaviour charts to record incidents of behaviour that may challenge, the section for 'triggers' often had the word 'None' in it. Staff had not analysed what had taken place leading up to the persons behaviour. As such, valuable information about what may be affecting the person and prompting the behaviour was lost.

The failure to manage risks to people's health and safety, and lack of safe management of medicines was a continued breach in regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

● Staffing levels had been increase since our last inspection in December 2018. However, peoples care and support were still impacted by issues around staffing levels and how they were deployed.

● The manager told us that staffing was now four care staff during weekdays and one waking night. At weekends there were three care staff during the day. However, when we arrived at the home, due to staff sickness, there were only three care staff on shift. This went up to four at midday when another member of staff came onto shift.
● People had greater access to activities since our last inspection due to increased staff deployment, however this still needed improvement. Some activities had been cancelled or delayed due to lack of staff. For example, one person had been unable to attend church due to no driver. One person's trip out was delayed on the day of our inspection. They had to wait for an additional staff member to arrive at the home, as they were on two to one support when going out into the local community.
● Current staffing levels and issues meant that some staff were working long hours to try to ensure people received a safe level of care. The night staff member was new, and still going through their induction. To ensure this induction took place, a member of the day shift often stayed until the early hours of the morning to support and train them.
● On the day of our inspection this staff member had finished work at 12:30 in the morning, and had to come into work on the day shift on their day off to cover staff sickness. This left them at risk of being tired and overworked, increasing the risk of mistakes.

Failure to have sufficient numbers of staff deployed at all times was a continued breach in Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection
● People lived in a clean home, and the risk of spread of infection was managed well.
● The carpet leading to the top floor bedroom needed cleaning. The rest of the flooring in the house was laminate, and was seen to be clean at the inspection.
● Peoples rooms were cleaned by staff each day after they got out of bed. People were not currently involved in cleaning their own room, this is something that could help to increase people's independence. To be encouraged to clean their own room was also included in at least one person's care plan, although nothing had been recorded to show staff were doing this.
● Staff were seen to wear protective equipment such as aprons when carrying out cleaning.
● Issues with decoration had been addressed since our last inspection. Broken tiles in the bathroom had been replaced, which made cleaning easier and more effective.

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

There were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care. Some regulations were not met.

● At our previous inspection in December 2018 we rated this domain as Inadequate. This was due to failures across the domain.
● At this inspection we identified that although some improvements had begun, the concerns had not yet been fully addressed by the provider.

Continuous learning and improving care
● Because of the last inspection in December 2018 some improvements had been made at the home. However, this was ongoing and key areas, such as supporting people and staff to understand and overcome behaviours that may challenge had not yet been fully addressed.
● Actions taken had not always been effective at addressing the concerns. Although medicines training had been given to staff, errors were still being noted by health care professionals that visit the home. Incidents and accidents were still not being appropriately reported or managed, even though this was an area clearly identified as needing improvement at the previous inspection.

Failure to adequately assess, monitor and improve the quality and safety of the service was a continued breach in Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Planning and promoting person-centred, high-quality care and support with openness; and how the provider understands and acts on their duty of candour responsibility
● The registered manager had resigned and left the home since our last inspection in December 2018. Two registered managers from other homes were spending time to support staff at Redstone House and drive improvements in the care people received. These services were owned by the same people that owned Oregon Care Ltd, although were registered under separate company names with the CQC.
● The two managers said they felt supported by the owners of the services and they could make improvements, however there was a lot to do and it would take time.
● The two managers also had their own homes to manage and although recruitment was underway to employ a new registered manager at Redstone House, no one had been employed at the time of the inspection.
● One of the managers said, "[Managers name] from Rosewell (another care service) has been helping us out a lot, coming in and fixing things and paperwork, me and the staff have just been looking after the house and service users. From my point of view, there's been so much improvement in the house and its ongoing."
● The other manager said, "We can't just sit and watch it (Redstone House) go downhill."
● Both managers and the care staff at Redstone House were positive during our inspection and were keen

for people to have a better standard of care and support.

● Services that provide health and social care to people are required to inform the Care Quality Commission (CQC) of important events that happen in the service. The manager had not informed the CQC of significant events, such as incidents that could be safeguarding.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

● Staff at the home understood their roles and were striving to improve the standard of care and support given to people. However, the structure of the organisation that owned Redstone House was unclear to them.

● The owners of the business were not available to discuss concerns about Redstone House with the CQC on two occasions when requested. This, in addition to concerns raised by the local authority safeguarding team about a perceived lack of improvement at the home, prompted this responsive focussed inspection.

● Staff that represented the owners of Oregon Care, and carried out key tasks such as financial audits and quality assurance visits were away at the time of the inspection. This left staff at the home unable to access information to demonstrate if the service was well led.

● The nominated individual registered with the CQC for Oregon Care was the registered manager of another care home. They told us that they had been unaware that they were the nominated individual for Oregon Care Ltd, nor the responsibilities the role entailed. A Nominated Individual has overall responsibility for supervising the management of the regulated activity, and ensuring the quality of the services provided.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others

● Equality characteristics had not always been considered. During the inspection one person was seen to hug people, staff and visitors of the same gender. When we asked staff if there was a reason for this, or if they had explored the person's sexuality as a possible reason they had not thought about it.

● Letters to relatives had been sent out to the families of people to inform them of the results of the previous inspection. However, no meetings had been held with the people who used the service.

● There was on going work with the CPLDT around staff completion and review of behaviour incident records. More staff education and understanding was needed around this if they were going to fully understand people's behaviours and the triggers that cause them.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Failure to manage risks to people's health and safety, and lack of safe management of medicines.

The enforcement action we took:

We imposed a condition

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Failure to identify and report safeguarding incidents

The enforcement action we took:

We imposed a condition

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Failure to adequately assess, monitor and improve the quality and safety of the service

The enforcement action we took:

We imposed a condition

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Failure to have sufficient numbers of staff deployed at all times

The enforcement action we took:

We imposed a condition