Oakdene Residential Home Limited

Oakdene Residential Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection took place on 9,10,11 and 16 August 2018. The first day of the inspection was unannounced.

Oakdene Residential Home is a 'care home'. People in care homes receive accommodation and nursing or 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.

The home is registered to provide accommodation and personal care for up to 16 people. At the time of our inspection 10 people were living at the home.

The home required and had a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The registered manager delegated the day to day running of the home to a relief manager. The relief manager had been working at the home since March 2018, however the registered manager is still legally responsible for the safe running of the home.

During our previous inspection in January 2018 we rated the service overall 'Inadequate'. Since then the service has been in 'special measures'. This inspection was to see if significant improvements had been made within this timeframe.

At this inspection there was breaches of Regulation 9, 10, 11, 12, 13, 17, 18 and 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. There was also a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

The provider had not addressed many of the significant shortfalls identified at the last inspection and in some areas people's care had deteriorated. The systems the registered manager had in place had not ensured that the service was safe and was providing effective care for people.

Some improvements had been made to the environment of the home and the safety of the administration of medication. However, parts of the environment were still not safe for people. We asked to see a copy of the risk assessment for the home's refurbishment works and we were not shown one. Systems at the home did not always reduce the risks to people's health and wellbeing.

The procedures at the home to protect people from abuse or avoidable harm were not robust. For example; the registered manager could not be assured that new staff had been safely recruited. People had not received effective support to manage their healthcare needs and; appropriate steps had not been taken to ensure that people's legal rights were protected.

There had not been significant improvements in the training and support of staff members. Staff had not

received appropriate support, training, supervision and appraisal to enable them to carry out their duties effectively.

The provider had still not ensured that people had always been treated with dignity and respect. People's food and the support they received to help them eat, did not always meet their needs and reflect their preferences.

Areas of people's care files that had been updated were person centred. However sufficient improvements had not been made to ensure that people's care plans accurately reflected their needs.

Systems at the home that should assure the registered manager that care provided is safe and of good quality, were either missing or not working effectively. This meant that people had continued to receive care that was not safe, effective or responsive to their needs and placed them at risk of avoidable harm and of receiving inappropriate care.

There had been some refurbishment to the environment of the home and standards of cleanliness had improved. It was evident that staff knew people well and that positive relationships had been formed.

The overall rating for this service is still 'Inadequate' and the service is therefore in 'special measures'.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the registered provider's registration of the service, will be inspected again within six months.

The expectation is that registered providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the registered provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the registered provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Parts of the home's environment were not safe.

Systems at the home did not mitigate risks to people's health and wellbeing.

The procedures in place to protect people from abuse were not robust.

The registered manager could not be assured that new staff had been safely recruited.

The safety of medication administration had improved. However, issues highlighted during audits had not been investigated to ensure people were safe.

There had been some refurbishment to the environment of the home and standards of cleanliness had improved.

Is the service effective?

Inadequate

The service was not effective.

People had not received effective support to manage their healthcare needs.

Appropriate steps had not been taken to ensure that people's legal rights were protected.

Staff had not received appropriate support, training, supervision and appraisal to enable them to carry out their duties effectively.

People's food and the support they received to help them eat, did not always meet their needs and reflect their preferences.

The premises had been adapted to meet people's physical needs.

Is the service caring?

Requires Improvement

The service was not always caring.

The provider had still not ensured that people had always been treated with dignity and respect.

It was evident that staff knew people well and that positive relationships had been formed.

Staff demonstrated a caring approach in their day to day interactions with people.

Is the service responsive?

Requires Improvement

The service was not responsive.

This provider had not ensured that people's care plans accurately reflected their needs.

Care plans for people's health care needs had not ensured that they had received appropriate support to attend screening and treatment appointments.

Areas of people's care files that had been updated were person centred.

there had been some improvements in the activities available to people at the home.

Is the service well-led?

Inadequate

The service was not well-led.

Systems at the home that should assure the registered manager that care provided is safe and of good quality, were either missing or not working effectively. This meant that people had continued to receive care that was not safe, effective or responsive to their needs and placed them at risk of avoidable harm and of receiving inappropriate care.

The registered manager had not taken steps to rectify many of the areas that needed improvement, even when these areas had been previously highlighted to them.

The provider had failed to maintain secure, accurate and complete records of the care provided to people.

The provider had not ensured that they had fulfilled their obligation to inform the Care Quality Commission (CQC) of certain events affecting the health and wellbeing of people.

Oakdene Residential Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 9, 10, 11 and 16 August 2018; the first day of the inspection was unannounced. It was carried out by two adult social care inspectors. On the 11 August an inspector visited briefly to ascertain the staffing levels over a weekend.

Before our inspection we reviewed the information we held about the home. We spoke with the local authority to gain their perspective about the service.

We looked at the care records for four people living at the home, four staff personnel files and records relevant to the quality monitoring of the service. We looked round the home, including people's bedrooms, the kitchen, bathrooms, garden and the lounge areas.

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

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

Inadequate

Is the service safe?

Our findings

During our inspection in October 2016 we identified breaches of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the provider had not ensured that the premises and equipment were safe to use and were used in a safe way. At our inspection in January 2018 we found that the provider had failed to make the required improvements. This was a continued breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During this inspection we found that some improvements had been made in the safety of the environment at the home. Some refurbishment and maintenance work had taken place. However, sufficient attention had not been given to ensuring the safety of the environment at the home. The provider had been reactive and had not assured themselves, by the means of effective checks or audits that the environment was continually safe. It is the responsibility of the provider to ensure the environment is safe, not to address concerns that have been highlighted to them.

The upstairs fire doors were now alarmed, however on the first day of our inspection one of these was unsecured and could be opened from the fire escape outside. This had been like this at least overnight meaning the building had not been secure. In the same room decorators had left paint and turpentine in a room that people had access to. On another day the room was left with raised floorboards, power tools with a step ladder in place outside the door; all accessible to people. In one person's room a cupboard containing the home's hot water heaters, hot water pipes and electrics, was unlocked and could be opened. The electrics did not look properly secured to the wall and there were bricks and a heating element on the floor. We were told by the provider that a tradesman had accessed this area two days earlier and did not secure the area. The person who used this room was visually impaired, placing them at increased risk.

We asked the provider if there was a risk assessment for the renovations taking place at the home. They told us, "I think we have got one." We asked to see this assessment, but this was never provided to us. We also noted that the builders were not signing in and out of the building.

On our first day of inspection the door to the cellar was only secured with a bolt that people could easily open. This led to a steep flight of stairs that posed a risk to people if they accessed them. After highlighting this to the registered manager it was the same on the second day of our inspection. The door to the laundry area that led straight onto stairs could also be opened by the handle. Access to the laundry area had been previously raised as a concern with the provider. By the fourth day of our visit there had been keycode locks fitted to these doors.

At our previous inspection the home was not clean and hygienic. During this inspection we saw that some improvements had been made in the cleanliness of the home and some refurbishment had taken place in the areas previously identified. There were now appropriately equipped hand washing facilities and hand sanitising gel was available around the home. Substances hazardous to health were now appropriately stored.

However, the rusty toilet frame that would be difficult to ensure was clean was still being used. There was a daily cleaning schedule document that had been in place for about a month. The cleaner had made notes about certain rooms at the bottom of the document. We saw that for over three weeks the cleaner had written that there were two rooms in which there were smells that were not removed by daily cleaning and a deeper clean was needed. During our inspection these rooms still had odours. The cleaner had also noted a week earlier that an upstairs hallway with no window for natural light had no working light, leaving it in darkness. This was only resolved on the second day of our inspection. This showed that concerns highlighted during cleaning were either not being fed back to, or were not being acted upon and the cleaning records were not being checked.

Since our previous inspection in January 2018 some improvements had been made to ensure the fire safety systems in the building were safe. In March the fire alarm system and emergency lighting systems were checked; during which failing components of the fire alarm system were replaced. Firefighting equipment had been checked. The upstairs fire exit doors were now alarmed, alerting staff if they were used. Also, the home had a new emergency fire action plan dated May 2018 and we saw records of monthly checks of the fire doors and fire exit doors. In June it was recorded that there were two partial evacuation drills also, we didn't see any doors being wedged open.

In January and May 2018 Merseyside Fire Service visited the premises and reported that the fire risk assessment was not adequate and it was recommended that the document was revised. An appropriate fire risk assessment is now in place. Merseyside Fire Service also recommended some maintenance work to take place on the outside fire escape.

Records at the home showed that only half of the staff at the home had received fire safety training; and because of a lack of recorded induction for agency staff the relief manager could not demonstrate that they had been informed of the fire procedures at the home.

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

During our previous inspection we saw that the information in people's personal emergency evacuation plans (PEEPs), was not up to date regarding their support needs. These had now been updated, however not all the highlighted necessary improvements had been made. There was no building floor plan in the emergency grab file to identify bedrooms where people may be sleeping. People's PEEPs did not have people's room number and only contained generalised information about them. For example, some stated, people 'can occasionally present some behaviour that challenges.' They did not say what this behaviour may be or how to support the person. Two people living at the home did not have a PEEP in the emergency file.

At our previous inspection the first aid box only contained three different items. There was no inventory to detail what the first aid box should contain. At this inspection there was an inventory in one of the three first aid boxes. However, the first aid box with the most stock contained just over 50 percent of the items on the inventory, the others were significantly lower than this. The system in place for ensuring first aid supplies was still not working.

This is the third inspection where we have found that food was not being stored safely. At this inspection there were improvements in the labelling of food in the kitchen fridge. But when opening a freezer, we saw on the top uncovered raw meat, wrapped but unlabelled and undated meat and opened boxes of food not sealed. The provider has not put adequate systems in place to ensure that the food at the home is safe to

eat.

People had call bells in their room to alert staff that they needed support. The call bells made an audible alert on the ground floor for staff, however they did not identify a person or room number from which the call was made. We tried a call bell and saw that a member of care staff was checking all the rooms. This has the potential to delay people receiving help from staff when needed.

Information about accidents and incidents was recorded by staff members on an accident book pad. We found the information to be incomplete and information difficult to find as the records were in disorder. This information had not reviewed by the registered manager or relief manager, to enable them to be aware of the accidents that had happened and act to reduce risks and improve people's support. The information was therefore not used to update people's care plans.

The provider had not ensured that the systems at the home mitigated risks to people's health and wellbeing.

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

The procedures in place to protect people from abuse were not robust. For example, at our previous inspection the manager told us there were on-going police investigations into allegations of financial abuse. At this inspection we saw that procedures still did not safeguard people from financial abuse. We checked two people's financial records and found that they had not been correctly completed. Staff had made a number of handwritten and undated receipts and there were large cash machine withdrawals with no receipts. Some financial records did not make any sense and did not add up. Financial audits had been completed monthly and these had not picked up on any of these concerns.

For one person there were inappropriate financial transactions between the person and staff members and the money present was less than that recorded. We made a referral to the local authority safeguarding team for this person as they were at risk of financial abuse.

People were receiving safeguarding training during our inspection. However, records at the home showed that less than half of the staff members at the home had completed training in safeguarding vulnerable adults. At our previous inspection staff did not know what external organisations it was appropriate to make a safeguarding referral to if they needed to. At this inspection staff still did not have this knowledge. The home had new policies in place on whistleblowing and safeguarding; but these did not give staff the details of outside organisations they may go to.

The provider still didn't have adequate arrangements in place to protect people from the risk of abuse.

This is a continued breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This is the third inspection where we found recruitment of new staff at the home to be unsafe. We looked at the recruitment files for four recently recruited staff members. Three of them did not contain sufficient information for the registered manager to assure themselves that staff were safe to work with vulnerable adults.

Employers are required to obtain satisfactory evidence of the applicants conduct in previous employment in

health and social care and why this employment ended. Usually this is done in the form of references. Some files did not contain references from previous employers or show that these had been sought. Some that were present were missing essential information. The references had not been checked in any way by the relief manager of the registered manager. Staff files were also missing evidence that staff members identification had been checked and information about applicants work history.

Each staff member had a check with the Disclosure and Barring Service (DBS). The DBS carry out a criminal record and barring check on individuals who apply to work with children and vulnerable adults. This is one way to help employers make safer recruiting decisions.

There were three people working at the home by an arrangement with a third-party care home. They were not employees of Oakdene Residential Home; however, the registered manager still needs to assure themselves that they are of good character and are suitable to work with vulnerable adults. They cannot transfer this responsibility to a third party. On the first day of our inspection the registered manager held no information about the three staff members being used under this arrangement to provide a regulated activity.

The provider had continued to not maintain a record detailing all the required information about new staff members.

This is a breach of regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There had been some improvements in the management of people's medication and guidance available to staff. People's medication was now securely stored. The medication was administered and recorded when people required it, not in advance as had happened previously. Staff members had received training in medication administration and their competency in doing so had been assessed. The competency of staff from a third-party care home had not been checked.

We still had some concerns with the way medication was managed at the home. For example, we saw that a box of one person's medication had a sticker with instructions on it handwritten by a staff member. This caused a problem as it covered the instructions and a warning notice from the pharmacy dispenser of the medication. This information should not be covered by staff who are administering medication. We highlighted this poor practise to the relief manager.

There were systems in place to record and guide staff in how and when to administer people's as required medication (PRN). Often, we saw that the reason why PRN medication had been given was not recorded. This makes it difficult to monitor the use of this medication.

Medication audits were now taking place but there was no record of any actions or further investigation taken place when concerns were highlighted. For example, in July 2018 four people's medication audits showed these people had more medicines in stock that the records indicated would be in stock. The home's policy on medication errors states that when an error in administering medicines is discovered or suspected an accident/incident or medicines error reporting form would be completed documenting the details, any action taken and the outcome. The registered manager referred us to the relief manager. The relief manager told us that these had not been done. Two of the audits stated that "Staff need to be more vigilant", no further action had been taken. We recommended to the registered manager that the results from these audits are investigated.

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

During our previous inspection we noted that staff were not deployed in sufficient numbers at all times to meet people's individual needs and protect them from harm. During this inspection the provider had maintained the same staffing levels. However, the number of people living at the home had decreased from 14 to 10. During this inspection we saw that there were sufficient staff to meet people's needs. To do this they made use of staff from another home under an agreement.

Inadequate

Is the service effective?

Our findings

People had not been effectively supported with their healthcare needs. We saw letters giving details of appointments for treatment, healthcare, diagnosis and screening; that had not been passed onto people or stored in their care files. We asked the registered manager and relief manager if people had been supported to make or attend these appointments. They were unable to assure us that people had been supported to attend their appointments, or were unable to find out if any other arrangements had been made.

Examples of the letters included; one person had two reminder letters from December 2017 and January 2018. These letters informed the person that it was important that they made an appointment for a medical screen. We spoke with this person, who had the capacity to understand these letters and told us that these letters had not been shared with them and they had not attended an appointment. Another person had an appointment letter which the registered manager or relief manager could not confirm had been attended. When we looked at the care records for the day of the appointment, no reference to the appointment had been made. We referred this matter to the local safeguarding team.

People had not received effective support to manage their health care needs.

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

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The 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.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

Staff at the home did not know if there were any restrictions in place for people. One staff member told us that some people had a DoLS in place but they didn't know who. They told us, "We would prevent most people from going out on their own." Another senior member of staff told us that there were three people at the home with a DoLS authorised, they then changed this to telling us there was "possibly four." Two staff members told us that training on the Mental Capacity Act and DoLS had been arranged but that this did not happen.

Some people's care files stated that a DoLS had been authorised, but there was no evidence of this. The relief manager told us that renewals of DoLS had been requested for three people. However, the local authority told us that applications for renewals had been requested but not returned. Of the four people we were told had a DoLS authorised or applied for the local authority told us that only one DoLS was in place

and no applications had been made.

We saw that for one person staff had signed a document on a person's behalf relating to their healthcare. The person had capacity and there was no evidence of consultation with the person.

The provider had not taken the appropriate steps to ensure that people's legal rights were protected.

This is a continued breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw and people told us that they were supported to make day to day choices for themselves. For example, on when to wake up and when to retire for the night.

Staff members had not received appropriate supervision and support in their role. The relief manager told us that they had completed two supervisions for staff members since coming to the home in March 2018. There was no evidence that new staff members had received an appropriate induction or supervision into their new role, some of whom had not worked in social care before. There were two induction records but these were incomplete.

There was currently no arrangement in place for staff to receive updated information and guidance during staff meetings. The registered manager and relief manager had recently held one staff meeting. They described to us that this meeting was not constructive and that there was infighting amongst the staff team and the meeting had to be stopped by the relief manager. There were no minutes from this meeting.

Some training had taken place in safeguarding, first aid and administration of medication since our previous inspection. Staff had not received training in moving people safely, although we were told this was booked. Less than half of staff had completed safeguarding and fire safety training and one staff member was trained in food hygiene despite all staff being involved in preparing food.

Staff had not received appropriate support, training, supervision and appraisal to enable them to carry out their duties effectively.

This is a continued breach of Regulation 18 of the Health and Social Care Act (Regulated Activities) 2014 Regulations.

We observed one lunchtime, we did not see any menu on display. The relief manager told us afterwards that people are personally asked what they want to eat from the menu options. We saw that one person had food that did not reflect the tastes and preferences that staff told us they had. They had been served, breaded chicken, green beans and potato waffles. One member of care staff told us that the person likes, "Old fashioned, old school food like scouse [beef stew]." Another told us the person likes their food chopped finely like "shredded chicken". This meal didn't appear to match the person's preferences.

We saw that the person was struggling to feed themselves with a spoon. They were trying to scoop up the food but was not getting any on their spoon. We observed them putting an empty spoon into their mouths five times in a row. A staff member came and brought the person a drink, without offering the person a choice and left. The person got their spoon stuck in the handle of the beaker and they spilt food down their clothes, they did not have a protective cover on. We alerted a staff member that the person was having difficulty with their food. We were told that they need their food cut up very finely, however their food was in large chunks. We saw that another person was using their fingers to eat ice cream. A third person ate very

quickly and was coughing and a fourth person's food was cut into large pieces and they struggled to get their food into their mouth. Staff were busy coming and going, there was not a dedicated staff member to support people in the dining room to have a pleasant dining experience.

The provider had not ensured that people's support with their food at the home met their needs and reflected their preferences.

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

We spoke with a staff member who was providing food for people. They showed us that two people with specific diets had this catered for. We saw that people who chose to eat in the dining room were served at tables which were laid out with cutlery and a table cloth. Other people were served food in their room.

The premises had been adapted to meet people's physical needs. A bathroom on the ground floor contained a bath hoist to transfer people in and out of the bath. There were two stairlifts that people could use independently or with support to access the first floor. There were no adaptations to help people living with dementia to orientate themselves around the service.

Requires Improvement

Is the service caring?

Our findings

We saw that staff were often considerate and respectful to people in their day to day interactions. It was clear that some staff had positive relationships with people. We spoke with one family member who told us, "The carers adore my mum. I'm quite happy [with the home] at the moment." Another family member showed us a card they had written to the home. In part it said, "You all added to making her last two years so much happier. I can't thank you enough."

There were no restrictions at the home and people told us that they got up and went to bed when they wanted to and not for the convenience of the service. However, the way people's care was delivered and organised meant that they were not always treated with dignity and respect. For example, people's private and confidential personal information was not protected and treated with respect. There was a range of private medical and financial documents along with unopened and opened correspondence belonging to multiple people, in disarray in one of the lounges.

Previously we had noted that people's confidential information relating to aspects of their care was stored in a folder on top on the medication cabinet in the hallway, to which people and visitors had access. On the first day of this inspection we found this to still be the case.

When one person had received mail, for example in relation to their health care; this had not been given or read to them. They had not been made aware of the mail, been consulted with or their response sought.

One person had moved rooms because the room they had been in was being refurbished. The person's bed was not moved with them. The person said that their new bed was lumpy, not big enough and was uncomfortable. The person had been changed from a divan style bed to a hospital style bed with an airflow mattress. The person did not need this type of bed, they had not been asked about this and the airflow mattress had been unplugged causing it to deflate and be uncomfortable. There was a screen and hoist being stored in the room that the person does not use and boxes were blocking access to the sink. We spoke with the relief manager about this as this person had not been treated with respect when moving rooms.

Information was still not provided to people to enable them to make choices. For example, there was no information on display about what the menu was for the day or what alternatives were on offer. Some people living at the service were visually impaired and some other people were living with dementia. However, none of the information we saw was available in any format other than written and there is no evidence that this information was ever read to people.

There was no evidence of any family involvement in the formulation or reviewing of people's care plans. There was nothing to indicate any discussion had taken place with the person or their family or whether they had been asked if they were happy with the way their care was provided.

There had been improvements in some areas. For example, we did see that inappropriate signs had been removed from the walls in people's rooms, and staff spoke about people with respect. However, the

provider had still not ensured that people had always been treated with dignity and respect.

This is a continued breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

It was evident that staff knew people well and that positive relationships had been formed. Staff demonstrated a caring approach to people. For example, we observed that staff were genuinely interested to hear how people were feeling and saw some tender interactions with people. We heard staff addressing people in a gentle manner and offering reassuring and a comforting hand or arm when needed. Staff were also aware of people's full names and how they preferred to be addressed.

Requires Improvement

Is the service responsive?

Our findings

At our previous inspection we saw that the provider had not ensured that people's care plans accurately reflected their assessed needs. During this inspection the relief manager told us that they had fallen behind with managerial tasks and acknowledged that people's care plans were out of date. They explained they were in the process of updating them but they had taken on other aspects of managing the service. They told us that they had "started again" with the care planning process and one person's care plan had been fully updated. Lots of people's care plan information remained the same as it was during our previous inspection.

There was a mix of two systems being used and confusion amongst staff on how people's care records were being kept. One staff member told us that they were using a computer tablet and these records were being kept electronically. The relief manager told us that the staff were still using paper records.

Areas of people's care files that had been updated were person centred. For example, one person's care file now contained information for staff on their cognition, communication, diet, medication, safety and other care needs. Some information had been added to people's care plans on their preferences, likes and dislikes. For example, we saw in one person's 'This is me' section details of the foods they enjoyed and what they found comforting during the day.

Some people's care files had been updated after significant events. For example, after one person had experienced a fall, their safety care plan and falls risk assessment had been reviewed. For another person their moving and handling care plan had been updated after they had a fall.

However, some of the information didn't reflect people's needs or the care they received. For example, one person's care file on the person's communication did not mention them having a hearing problem and how staff supported them with their hearing aid. This was after there had been a complaint about ensuring the person had a working battery in their hearing aid and the person being supported to have their ears checked.

Another person had their pressure relieving mattress set to 85Kg when the person weighted significantly less than this. There were no guidelines for staff and the use of their pressure relieving mattresses in the person's care plan. The person's care plan also said they had fork mashable food and we saw the person was eating breaded chicken. We were told this was an inaccuracy in the person's care plan. Care plans for people's health care needs had not ensured that they had received appropriate support to attend screening and treatment appointments.

There were now more details on people's daily notes. However, once these daily notes had been completed they were not periodically checked, weekly or monthly and the information used to update people's care files.

The provider had not ensured that people's care plans accurately reflected their needs.

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

At the last inspection we saw that there had been some improvements in the activities available to people at the home. There was no activities plan, or records of activities that had taken place. However, we did see photographs of the things that some people had been doing at the home. One person's family member told us, "There is now so much more going on. Before there were not enough activities going on." The family member described how the garden had been used more during the good weather, entertainers had been into the home and people had enjoyed playing bingo and celebrated the royal wedding. On one day we visited people had a hairdresser visiting. One person told us that they had a regular visit from a local member of clergy and take Holy Communion. Since our previous inspection there had not been any development of activities focused on people who were visually impaired.

People told us they would speak with the manager if they had any concerns or complaints. Information about how to complain was in the home's complaints policy which was displayed in the entrance hall.

Inadequate

Is the service well-led?

Our findings

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

On the first day of our inspection we saw that stacks of documents were stored in various places in one of the lounges. This lounge was available to people living at the home, visitors and staff. Some of these documents were people's recent care records, NHS records, private letters and financial information. These contained sensitive personal information. There were also numerous pieces of people's unopened mail, some addressed to people who had the capacity to open and deal with their own mail with support.

There was also confidential information about staff members; such as financial information and personnel records. Along with safety information about the home and staff communication records.

On the second day of our inspection we became aware of another box of documents in this lounge. They had been accessible because they were under cushions and behind a recliner chair. This box also contained people's private correspondence, some relating to health appointments.

At first the registered manager told us that they knew nothing about these documents and how they came to be stored in this way. Later, we were told by the registered manager that they found out these documents had been moved by staff members to this lounge from the staff room. This happened because the staff room was now used as a clean linen store after recommendations made by the infection control and prevention team to have a clean linen store. This meant that for some time the registered and relief managers had not known the location of essential records or had asked what had happened to the care records in the staff room.

The disorder of these documents and records meant that the registered and relief managers were unable to answer many of our basic questions when we were trying to ascertain if people had received care appropriate to their needs. The maintenance of people's records at the home had deteriorated since our previous inspection.

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

The disorder with information meant that the registered manager or the relief manager could not assure themselves that people had received appropriate care. When we looked into some incidents that happened at the home they were not able to obtain information. For example, when we saw that one person had an appointment at a fracture clinic and we were unable to find any record of the accident where they had

sustained that fracture.

The provider had failed to maintain secure, accurate and complete records of the care provided to people.

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

The leadership at the home was reactive and chaotic. It was not clear what people's responsibilities were at the home. The relief manager told us that, "Staff are not clear who to go to." They also told us that people were not clear about their role as, "A lot of stuff is generalised" and not written down. The relief manager also told us that they had not received an induction into the workings of the home and they had not had a formal supervision where the agreed actions had been documented. They told us that they spent time with staff members to get a general feel for the home.

Staff had not been receiving appropriate guidance in their role. There was limited supervision and one staff meeting that had been held, had to be stopped early by the relief manager because of disruption. The registered manager put the responsibility for this onto staff, however not being able to conduct an effective staff meeting demonstrated a poor culture within the home.

There was a schedule of improvements in place for the home. This schedule focused on the building, it was vague and had a timescale of two to three years. A maintenance schedule was referenced in this document but when we asked for a copy of this, it was not available. There was no action plan in place that either the registered manager or relief manager could show us, to demonstrate how they planned to improve the service provided to people, or to show how areas of concern highlighted during our previous inspection were going to be addressed.

The systems at the home that should assure the registered manager that care provided is safe and of good quality, were either missing or not working effectively. We had previously raised this in 2016 and again in January 2018. The relief manager told us that they had some systems in place however they had found completing them difficult due to being distracted with ongoing issues at the home.

Examples of systems not working include; the medication audits that had highlighted information of concern and had not led to any investigation or action to ensure people were safe. Areas of concern had been highlighted on the cleaner's daily records, however these had not been addressed for some weeks.

Accidents and incidents that happened at the home had not been checked or audited in any way. Financial audits of people's monies, some of whom had ongoing investigations for financial abuse at the home, had not been effective in ensuring that adequate records were now being kept and people's monies were not safe. Care plan audits had not ensured that even the most basic areas of care, such as supporting people to manage healthcare appointments had happened. Some people's care plans had been looked at since our previous inspection in January 2018, however this had been sporadic. Health and safety audits, about ongoing refurbishment works had not ensured that the environment was safe for people. We looked at some records in the maintenance book and saw that areas of the home identified as requiring maintenance in 2017 had not been addressed.

Staff recruitment systems had not been checked to ensure that new staff were suitable to work with vulnerable adults. Recruitment files had not been audited and there was no effective system of enquiring and checking the information that had been provided by applicants. For example, there were no documented interviews, people's references were not verified and applicant's work history was not checked.

The home was using three staff members from another home like agency staff. On the first day of our inspection the registered manager held no information about these staff members at Oakdene. We asked the registered manager how they assured themselves that these staff were suitable to work with vulnerable adults and had the skills and training to provide care and administer medication. The registered manager told us, "I have good faith that they [the separate care home] have done their checks really well."

There was a lack of oversight of DoLS authorisations and applications made on people's behalf. This meant that the registered manager had not ensured that people's legal rights were protected.

The registered manager and a director of the care home often resorted to blaming other people when we asked them questions about areas of concern within the home. This included blaming contractors, builders, visiting professionals, the local authority, the police and staff members. The registered manager did not take responsibility for the safety and quality of the service provided to people.

This is the third inspection where we have highlighted ongoing concerns with the oversight of and quality assurance systems within the home. The registered manager had not taken steps to rectify many of the areas that needed improvement, even when these areas had been highlighted to them. Since January 2018 the home has been in special measures, during which time the registered manager had not used the opportunity to take the corrective actions necessary. This meant that people had continued to receive care that was not safe, effective or responsive to their needs and placed them at risk of avoidable harm and of receiving inappropriate care.

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

At our previous inspection we informed the provider of their legal obligation to ensure that the Care Quality Commission (CQC) was informed of certain events affecting the health and wellbeing of people; this is by way of a statutory notification. However, during this inspection, we became aware of further notifiable events that we had not been informed about that had happened at the service since our last inspection.

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

The home had a new set of policies and procedures in place. We saw that these were available to staff members. We looked at the policies for whistleblowing and safeguarding. These directed staff to inform a director if they had any concerns. They did not highlight to staff the option of going to organisations outside of the home if appropriate; or provide their contact details.

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