Oxton Manor Ltd

Oxton Manor

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

Oxton Manor is a detached house providing care for up to 15 people with complex learning disabilities. The home is situated in Oxton on the Wirral.

This was an unannounced inspection carried out on 10 and 11 October 2016. These visits formed part of this inspection. We began this inspection due to information we had received from the local authority. Concerns we had received included the management style at the home and cleanliness of the building.

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.

During our inspection, we identified five breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulated Activities 2014 in respect of Regulation 9, 10, 12, 15, 17, and 18 of the Health and Social Care Act 2014 Regulations. These breaches related to person centred care, safe care and treatment, premises staff recruitment, training, supervision and the management of the service.

You can see what action we told the provider to take at the back of the full version of the report.

Parts of the environment were dirty, shabby and unsuitable for the people living there. Infection control standards at the home required improvement.

Care plans and risk assessments were difficult to navigate and did not provide up to date information to inform staff about people's support needs. Where people's needs had changed their care plan and therefore guidance to staff had not been updated. When other health professionals had been accessed this was not appropriately logged and this information was difficult to find. This placed people at risk of receiving unsafe care.

There were a few quality assurance systems in place but they did not operate effectively enough to ensure people received a safe, effective caring, responsive and well led service. Overall we found the management of the home inadequate.

Staff did not receive the training, support and supervision they needed to support people with complex needs. This placed people at risk of receiving inappropriate and unsafe care.

The overall rating for this provider is 'Inadequate'. This means that it has been placed into 'Special measures' by CQC. The purpose of special measures is to:

- Ensure that providers found to be providing inadequate care significantly improve.
- Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.
- Provide a clear timeframe within which providers must improve the quality of care they provide or we will seek to take further action, for example cancel their registration.

The service will 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 we will move to close the service by adopting our proposal to vary the provider's registration to remove this location from the providers 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

The building was shabby, parts of the building were dirty, untidy and in need of cleaning and repair.

People's risk assessments and care plans contained conflicting information.

Robust recruitment processes had not been followed.

Is the service effective?

Requires Improvement

The service was not always effective

Staff had not received appropriate induction, training and supervision to carry out their job role effectively.

Deprivation of Liberty Safeguards had not always been applied for in a timely manner.

People's mental capacity had been assessed in accordance with the Mental Capacity Act 2005.

Mealtimes were centred around the individual person.

Is the service caring?

Requires Improvement

The service was not always caring

There were limited opportunities for people to be involved in the running of the service on a regular basis.

Staff interactions with people was not always appropriate.

The confidentiality of people's personal information was maintained

Is the service responsive?

Inadequate

The service was not responsive

Support plans had not been adapted to make them meaningful to the individual and easy to read and understand.

Peoples support plans did not always reflect their needs.

Activity plans did not give a true reflection of what was taking place.

Keyworker meetings were not regularly taking place.

Is the service well-led?

Inadequate

The service was not well led

There were no effective quality assurance systems in place to monitor the quality or safety of the service. This placed people at risk of potential harm.

Records were not accurate and complete in respect of each person living in the home.

Some quality systems in place were not followed by staff and not checked by the manager meaning the manager did not have oversight of the service.

Oxton Manor

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 10 and 11 October 2016 and was unannounced. The inspection team consisted of one adult social care inspector and a and a specialist advisor (SPA). The SPA was a nurse with expertise in learning disabilities.

Prior to the inspection we asked for information from the local authority and we reviewed the information we already held about the service and any feedback we had received.

During our visits we spoke with three members of staff and two visiting professionals. Some people were unable to speak with us so we spent time observing the general support provided to people and daily activities in the homes lounge and dining room. We looked at care notes for five people who used the service, medication storage and records, five staff records, accident and incident report forms, health and safety records, complaints records, and other management records.

At the time of the inspection there were 14 people living at the home and 16 staff employed.

Inadequate

Is the service safe?

Our findings

Prior to this inspection we were made aware of an incident that had occurred in the home that had resulted in a safeguarding and police investigation. This investigation had resulted in significant and serious harm to a person who had been living in the home. During the inspection we became aware of other concerns regarding the service being provided to people.

We looked at the support files for people who lived at the service and saw that people had risk assessments in place, however risk assessments and care plans did not match. Examples of this being risks had been identified such as 'risk of falling', 'aggressive behaviour' and 'choking' but there was not a care plan in place to ensure that risk was minimised and that all staff knew what to do. Another example was the statement '[person] has been given tablets' again there was no information on why and there was nothing in the daily logs or risk assessments to indicate that there had been any health issues leading up to the tablets being given.

We saw one person had a falls risk assessment completed scoring '5' which placed the person in the high risk zone (The form stated that anyone with a score of 4 and above must have a care plan in place, there was no evidence of this in the support file. The service had identified a person was taking their medication for pain but there was nothing to show that the service had implemented a system for the person to communicate if they were in pain and no plan for their personal care needs. This meant that people were at risk of receiving inappropriate support that did not meet their needs.

These were breaches of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the provider and manager had not taken the appropriate action to provide care in a safe way for people who lived in the home.

During our inspection we toured the home and saw that it was visibly dirty and unkempt. The home had two communal lounges both had visibly dirty carpets. On the first day of inspection the curtains in the small lounge were down and left over an exercise bike that was kept in the corner., we asked about this and we were told they must have been taken down for cleaning there was no documented evidence of this and on the second day of inspection they had been removed, this left the windows with no cover. We saw that walls were damaged and there was dust and dirt on the floors. It was also untidy with towels left lying on the floor, crockery and cups being left on the floors of communal walkways, there were three empty cardboard boxes left in one corridor. These were moved when we brought them to the managers attention. These items were a trip hazard to those who were able to walk around the home.

During our tour we saw that each bedroom had an en-suite bathroom. We looked at seven bedrooms and their bathrooms and saw that the bathrooms were dirty. The showers had either mould or soap residue around the plug holes which indicated they had not been cleaned for some time. We looked at communal toilets and bathrooms again these were dirty, we saw the bath that had recently been used by a person living in the home had jets in it and these were again surrounded by what looked like soap residue. A downstairs toilet smelt of urine and an uncovered toilet brush was lying next to the toilet, the bathroom

itself was dirty and the sinks had looked like they had not been cleaned.

We asked the manager whose responsibility it was to ensure the cleanliness of these areas and we were told that there was a senior care staff audit that should be completed, we saw that this had not been completed since April 2016. We were also told that the people living at the service were to be supported to ensure their personal space was clean, there was no evidence of this being risk assessed or planned in people's support files.

During the inspection the manager arranged for additional staff to come into the home to clean it.

On the first day of inspection we saw a bedroom that had curtains hanging off the rails, on the second day of inspection the manager told us that it had been put it into the maintenance book to be rectified.

One bedroom had a damp patch on the wall, which appeared to have been there for some time. We asked if there had been a leak, the manager was unable answer. The person who lived in the room needed personal care each morning so staff would have been in the bathroom and therefore should have seen this. It had not been reported in either the maintenance book or to the registered manager.

These were breaches of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This is because the premises were not properly maintained.

We viewed five staff recruitment files and found that not all the appropriate recruitment processes had been followed. All files contained two references, some of which had not been validated. We noted that the files contained proof of identification and appropriate criminal records checks on each person. This was brought to the managers attention who said they would change the processes. We also saw how the service had followed their disciplinary procedures appropriately and in accordance with their own policies.

We looked at the systems Oxton Manor had in place for supporting people with their medication. We observed the procedure for the administration and audit of medication. We also looked at Medication Administration Record sheets (MARs) these were all signed appropriately. We observed the medication audit that was completed by the senior support worker which involved checking what PRN (as required) medication had been given to an individual, counting the PRN medication and logging that number. This was completed for everyone who lived in the home, there were no discrepancies, however we noted there were large quantities of PRN paracetamol for several people. We saw that the use of PRN was recorded appropriately.

The registered manager showed us two medication audits dated March 2016 and July 2016, we were told that there had not been time to complete these audits monthly with 'other things' to deal with but he acknowledged they should be done monthly.

Requires Improvement

Is the service effective?

Our findings

We looked at five staff files and saw that there was no evidence of any induction records. We asked two new staff what induction had been received. They told us of shadowing practice when first employed, this was not part of a robust induction process as both told us about how they were shown around the kitchen and told which mops to use, proper chopping boards and other similar information. Neither told us about the people they were supporting until they were asked.

We were told by the manager that the service was in the process of changing the training system as they had identified the current training as an "Ineffectual tick box exercise". The registered manager informed us that due to the change of training provider, the staff training documentation had been deleted by the previous training provider. This meant there was a possibility that the people living at the home were being supported by staff who did not have appropriate knowledge of people's conditions and needs. A visiting professional told us that they thought "Staff could do with some additional tuition on communication and interacting with service users".

We saw little evidence of supervisions being carried out with staff, what had been carried out was by senior support workers and had been inconsistent. Supervision is meant to provide staff and their manager with a formal opportunity to discuss their performance, any concerns they have had and to plan future training needs. On discussion with the registered manager we were informed that the senior staff had been had given an informal training session on how to supervise staff. The manager said he was trying to up skill seniors, this meant it was probable that support staff were having ineffectual supervision when and if it took place as it would have been with untrained senior support workers.

The home employed apprentices who were going through their training. These staff were supposed to work alongside existing staff during their training and not be used as a fully trained staff member providing support to people. This had not been the case and we were told by the training provider that they had previously had to raise issues about how many hours the apprentices were working in the home. Although this had been rectified this showed the service were using staff who potentially had not received appropriate training to support people with learning disabilities.

These were breaches of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the provider had not ensured persons employed at the home had received appropriate support, training, and supervision to carry out the duties they were employed to perform.

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 to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. The service was working within these principles. The registered manager was aware of the need to have all Deprivation of Liberty Safeguards (DoLS) applications completed, however the manager had needed to be reminded several times by the local authority to apply for a DoLS for one person living at the home.

We saw that mealtimes were centred around what was wanted by the people who lived in the home. Each person chose what they wanted to eat from what was stocked in the kitchen We saw evidence of four different meals being prepared for people. This was recorded in a 'meal book' for each person.

Requires Improvement

Is the service caring?

Our findings

We saw little evidence that people living at Oxton Manor were involved in planning the care they received or in the running of their home. We saw meeting minutes for one resident's meeting held in February 2016.

We saw that staff had been disciplined on their attitude towards a person living in the home and as the inspection was taking place we twice overheard staff using swear words when in conversation with each other in communal areas. We immediately brought this to the manager's attention. This is disrespectful to people and it is a matter of concern that it occurred whilst staff knew inspectors were on the premises as this indicated that the staff did not recognise how inappropriate this was.

During our inspection the service seemed busy and the people living at the service seemed to walk around the service freely, however we saw that sometimes interactions between staff and people living in the service did not seem appropriate, an example being that staff would try to move a person who wanted to sit with an inspector instead of leaving the person to move when they wanted. The staff did not recognise that Oxton Manor was this person's home they had the right to sit where they wanted. This indicated that staff did not always support people's basic human rights to make choices.

These examples are breaches of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the service users were not treated with dignity and respect.

We saw that the people living at Oxton Manor had been allocated a keyworker. The role of a keyworker is to build a relationship with the person and provide support to them, it is therefore important that the person gets to know them. There was no evidence that this had happened.

We asked to see a copy of a 'service user guide' or information provided to people living at the home. However this was not provided to us.

We saw that people had received support from advocacy services, mainly an Independent Mental Capacity Advisor if needed.

We observed people being encouraged to be independent, an example of this was we saw that a person was able to help prepare their own meal. We asked if people could have visitors at any time and were told they could.

We observed that confidential information was kept secure in the managers and seniors offices.

We spoke to a senior support worker who clearly knew the people living at the home well and showed that she was caring. She spoke about people with respect, she said she loved her job and felt good about making a difference.

Throughout the inspection we saw staff and the manager provide people with privacy, knock on their door

and await permission before entering the room and provide support with meals in a way that supported the person's dignity.

Nobody living at Oxton Manor was receiving end of life care at the time of our inspection.

Inadequate

Is the service responsive?

Our findings

We looked at five people's support files and care notes and identified concerns with information being held about people living in the home. The front of the support files had a form called "service user documents" this was intended for staff to sign when they have read the person's case file. Staff had not all signed these the most seen was seven. There were 16 staff employed at the time of the inspection.

We saw little evidence of anything being adapted to make it meaningful to the individual and easy to read and understand. There was very little presented with anything visual to help people understand their own care and support. Some of the principles of person centred care had ve been used such as a one page plan that identified people's strengths and needs and what people liked and admired about a person. However these lacked individuality.

We saw that there were some support plans in place for people living in the home including communication, daily living, housing, activities, however we saw that the information held was not sufficient to appropriately support people. Examples of this was that one person had no support plan in place to help with identified problems such as anxiety or risk of falling. Another person did not have a plan for support with personal care needs or for when they became agitated and would behave aggressively towards others. There were a number of gaps with recording and reviewing support plans and risk assessments.

The support files were difficult to navigate and we were unable in some cases to identify which professionals had been seen by people living in the home. Examples of this were we saw that one person had a health monitoring sheet that had 'bloods' written on it. Nowhere in the care file did this have an explanation of what it was for or the outcome. The staff recorded dates of appointments on care log sheets however these did not give additional information and were not always written in the person's daily log sheets. It was therefore difficult to know why someone had a blood test or a hospital visit. We did not see any plans for helping with weight or healthy eating and choices. One person had a weight monitoring chart that had last had their weight documented in January 2016. This identified the person's weight was above the health range but had not been highlighted in the persons health passport.

We looked at personal weekly activity plans for people and saw that they stated that keyworker meetings were to be carried out on a weekly basis. A keyworker is a named member of staff who has overall responsibility for understanding and ensuring an individual's needs are met. We saw that in the majority of the support files this was sporadic or hadn't happened at all. The senior support worker told us that these should be completed every month. This meant that the staff did not have awareness or knowledge of how often keyworkers should be meeting with people living at the home.

We also saw that people's activity plans had identified that they enjoyed a specific activity that had been discontinued in the home, however there was no updated activity or care plan. The staff held a crafts session in the dining room during the inspection, however there was no evidence that this was planned with people in their support plans. We saw generic terms such as 'need support at all times' this was not person centered and did not give information on how a person would need or want to be supported.

The inaccurate, generic and out of date information within care plans meant that staff did not have up to date guidance to follow in order to support people safely.

These examples are breaches of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the provider had not ensured that an up to date plan of care was maintained for people living in the home.

The home had a complaints' policy that had been updated in January 2016. We saw how the registered manager had logged and investigated complaints. We were also able to see the follow up actions. This indicated that complaints had been appropriately handled.

Inadequate

Is the service well-led?

Our findings

The home had a registered manager who had been in post since October 2015 and who was present during all days of inspection. The manager was supported by three senior support workers.

During the inspection we saw little evidence of any audits being carried out. One monitoring form was dated in July 2016 for dining room, laundry, dining room and basic health and safety audit however we saw no record of identified actions being carried out. The manager had carried out a monthly audit in November 2015 and none had been documented since. We saw that a 'Seniors Check list' that had been delegated to the senior staff to be completed for every 'senior shift' had not been completed since April 2016, this system had obviously not been checked by the manager. This meant that there were no effective quality assurance systems in place at Oxton Manor to identify risks to the people living there or to identify and plan improvements to the service. This included the risks we identified during this inspection.

We saw that staff team and resident meetings had not been carried out regularly, one of each had been held in 2016. This meant that people had not had a formal opportunity to put forward opinions or suggestions about the home. Staff were not safely inducted or regularly trained to provide safe care for people living in the home.

The home was visibly dirty and the manager only arranged for additional staff to clean it after the inspection had commenced and the inspector had raised significant concerns about the cleanliness and hygiene of the home.

These examples are breaches of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This is because systems and processes did not operate effectively to improve the quality and safety of the service provided.

We identified concerns regarding the records being kept on each person in the home as support plans and risk assessments were inconsistent and information recorded was conflicting. Daily logs for people living in the home contained inappropriate reporting language, this was also identified by a visiting professional. There was little evidence that staff had undergone effective induction or training, this was brought to the managers attention who said he was planning to change the way staff were inducted.

These examples are breaches of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This is because the service did not maintain an accurate, complete and contemporaneous record in respect of each person living in the home or persons employed by the home.

We saw that systems were in place such as quality checks of the building but these had not been followed by the staff. This had not been identified by the manager meaning the manager did not have oversight of the service.

We discussed the registered managers own supervision and we were told that he received peer support from

a manager from a sister home but none from the provider.

During our inspection we asked to see the policies the home had in place. Some of these had been updated and the manager told us he was in the process of completing the remainder.