Mrs R Ghai

Oak Lodge Residential Home

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 well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Oak Lodge is a residential care home providing personal care to 15 people aged 65 and over at the time of the inspection. Some people were living with dementia. The service can support up to 17 people in one adapted building which is laid out over two floors.

People's experience of using this service and what we found
Risks in relation to the premises were not always identified, assessed or managed. There was a lack of appropriate risk assessments and control measures in place to manage the risk to people posed by hazardous substances stored on the premises.

People did not always receive their prescribed medications and in accordance with their specific guidance. Medicines were always not stored safely. There were a number of issues identified with the management of sharps, a sharp is a device that has sharp points or edges such as needles and syringes.

Some people were receiving regular pain-relieving medication via (skin) transdermal patches. There were no charts in place to record the site of application of these transdermal patches or to confirm the removal of their previous patches.

Care records were not always completed accurately or clearly to demonstrate safe practice and enable effective monitoring to take place. We found numerous unexplained gaps in some peoples' repositioning charts.

Care records showed some people who had been identified as lacking capacity did not have decision specific capacity assessments and best interest decisions recorded for having bedrails fitted.

Governance systems and processes were not effective to monitor risks to people's care and to ensure care records contained relevant information.

Audits and maintenance checks completed by the provider had not identified the issues identified during the inspection such as unsafe equipment, inconsistent care recordings and care records lacking relevant information about people's health needs.

Systems were in place to protect people from the risk of abuse and harm. People were comfortable, relaxed and happy around care staff and staff understood how to keep people safe. Staff understood who to report concerns to as well as the risks to people's health.

Staff had regular training opportunities and training specific to people's individual needs was provided however improvements were required in relation to neglect and health and safety.

Staff had good knowledge and understood people's health conditions and the support they required.

Staff followed the infection control procedures the provider had in place.

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

Rating at last inspection
The last rating for this service was requires improvement published 21 August 2019

Why we inspected
The inspection was prompted in part due to concerns received about care delivery. A decision was made for us to inspect and examine those risks. As a result, we undertook a focused inspection to review the key questions of Safe, Effective and Well Led.

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to safe and care treatment, premises and equipment, the need for consent and governance.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe. And there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it. And it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not safe. Details are in our safe findings below.	**Inadequate**
Is the service effective? The service was not always effective. Details are in our effective findings below	**Requires Improvement**
Is the service well-led? The service was not well led. Details are in our well led findings below.	**Inadequate**

Oak Lodge Residential Home

Detailed findings

Background to this 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. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection was carried out by one inspector, a specialist advisor who was a nurse and one expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
Oak Lodge Residential Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

This service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. 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.

At the time of our inspection there was a registered manager in post.

Notice of inspection

This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. We used the information the provider sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections. We used all of this information to plan our inspection.

During the inspection
We spoke with three people who used the service and eight relatives about their experience of the care provided. We spoke with seven members of staff as well as the registered manager, senior care workers and care workers. We spoke to the nominated individual to ask them about how they monitored the service. The nominated individual is responsible for supervising the management of the service on behalf of the provider. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We reviewed a range of records. This included seven people's care records. We looked at two staff files in relation to recruitment. We also looked at a variety of records relating to the management and quality assurance of the service.
We sought clarification from the provider to validate evidence we found.

Inadequate

Is the service safe?

Our findings

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

At the last inspection this key question was rated as requires improvement. At this inspection this key question has changed to inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management

●Risks in relation to the premises were not identified, assessed or managed. For example, in one person's bedroom a plug socket was damaged, it was taped up with internal wiring exposed and left in an unsafe state. In addition, the wall-mounted staff call unit had come away from the wall and was hanging loose at the head of the person's bed with internal wiring exposed. Under the person's bedroom sink, the wooden housing concealing a water inlet pipe had become detached exposing a protruding nail. This placed the person and others accessing the room at risk of harm.

●One person's bedroom overhead door closure was broken, preventing it from closing automatically once opened. This placed the person and others in the home at risk in the event of a fire.

● Some people required regular support from staff with repositioning due to being at high risk of developing pressure damage to their skin. We found numerous unexplained gaps in some peoples' repositioning charts. Staff members we spoke with told us regular repositioning was taking place in line with peoples care plans. The unexplained gaps placed people at risk of neglect, for example new staff members unfamiliar with peoples needs may not have followed the correct repositioning schedule due to the inconsistencies with records.

● There was a lack of control measures in place to manage risks posed to people from hazardous substances. Hazardous cleaning products and other items such as screws and glue were stored in an unlocked cupboard, with no locking device, which people living at the home had access to. No risk assessment had been completed for hazardous substances stored on the premises and people were at risk of accessing these items.

Systems had not been established to assess, monitor and mitigate risks to the health, safety and welfare of people using the service This placed people at risk of harm. This was a breach of Regulation 15 (Premises and equipment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People had individual personal evacuation plans (PEEPS) to ensure they were supported safely in the case of an emergency. Staff knew what support they needed in the case of an emergency

Using medicines safely

● The provider had failed to ensure the safe storage of medicines. We reviewed the daily temperature logs kept for the medicines room and medicines fridge. Most medicines come with directions from the manufacturer to store below 25C. We found peoples' medicines had been stored above the recommended temperature for a period of nearly two months. This increased the risk of service users' medicines breaking down and becoming less potent due to being exposed to temperatures above the recommended range.

● Some people were receiving regular pain-relieving medication via (skin) transdermal patches. There were

no charts in place for staff to record the skin site application of the patch. Or, to record the removal of the patch. This is important to ensure the manufacturer's instructions are followed. Rotating the skin site used is important to avoid sensitivities developing. Thinning of the skin can develop if routinely applying the patch to the same area and the rate of absorption into the blood stream can be higher leading to overdose. There was no record of daily checks to ensure the transdermal patches remained in place between applications. These daily checks are important as patches are prone to falling off or accidentally being removed by the person. Where there are barriers to communication people could experience unnecessary pain.

● Two peoples' medicines records indicated there had been an unexplained one-day delay in the application of their pain-relief transdermal patches. We raised this with the registered who was unable to explain why there had been a delay. The unsafe management of peoples' transdermal medications placed them at increased risk of not receiving these medicines safely and as prescribed.

● There were unsafe practices related to the management of sharps in the home. A sharp is a device that has sharp points or edges such as needles and syringes. The sharps disposal units located in the home's medicines room had not been signed and dated when brought into use, to ensure removal after an appropriate interval, and were not located at suitable height to allow for safe disposal of sharps and to avoid spillages.

The provider had not ensured the proper storage and safe use of medicines. This left people at significant risk of their health conditions being left untreated. This was a breach of Regulation 12: (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff completed medication administration records (MARs) to show what medicines they had administered. However, staff did not always check to ensure people received their medicine when they should.

● Some people were prescribed 'when required' (PRN) medicines. Staff knew when to administer these and how to record this.

Systems and processes to safeguard people from the risk of abuse

● Staff had been trained and would report concerns related to physical abuse such as bruising but did not always recognise risks of neglect. The health and safety issues identified during the inspection demonstrated staff required more training and competency checks to ensure they were aware of the appropriate action to take to keep people safe. One staff member told us, "If I saw abuse taking place, I would intervene to make the person safe. I would then inform the management and record what I had seen." Another staff member told us, "If I was unhappy about how the home dealt with a safeguarding incident, I would tell you [CQC], local authority or the police."

● Risk assessments were in place however they did not consistently contain enough information to ensure people were safe. For example, two people had a catheter in place. No risk assessment or care plans had been developed for either service user in relation to the safe management of their catheter care. Staff we spoke with were able to tell us how they provided catheter management. After the inspection the registered manager sent us a new risk assessment detailing catheter management for staff members to follow.

● We observed people were relaxed around staff. Relatives told us their loved ones were safe and comfortable with staff members. One person told us, "I feel safe with them [staff members]".

Staffing and recruitment

● Recruitment checks were completed to make sure staff were safe to work with people. This included obtaining references from previous employers, and background checks with the Disclosure Barring Service (DBS). Disclosure and Barring Service (DBS) checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer

recruitment decisions.
● Staff told us they had received an induction when starting work, and had the opportunity to shadow other staff and completed training.
● Our observations during the day, indicated there were enough staff on duty to support people with their care needs. People and their relatives told us there was enough staff to meet people's needs.

Preventing and controlling infection
● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was meeting shielding and social distancing rules.
● We were assured that the provider was admitting people safely to the service.
● We were assured that the provider was using Personal Protective Equipment (PPE) effectively and safely.
● We were assured that the provider was accessing testing for people using the service and staff.
● We were somewhat assured that the provider was promoting safety through the layout and hygiene practices of the premises.
● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
● We were assured that the provider's infection prevention and control policy was up to date.
● People using the service were supported to maintain contacts with their relatives.

Visiting in care homes
●At the time of our inspection there was no restrictions on visiting and relatives were able to visit their loved ones at a time convenient for them.

Learning lessons when things go wrong
● We found accident and incident records were completed and monitored by the management team to reduce the likelihood of reoccurrence.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Ensuring consent to care and treatment in line with law and guidance
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. In care homes, and some hospitals, this is usually through MCA application procedures 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 had the appropriate legal authority and were being met.

● The provider had failed to ensure the principles of the MCA were followed as people did not always have their capacity assessed for specific decisions and best interests' decisions recorded as required. For example, records showed some people who had been identified as lacking capacity did not have decision specific capacity assessments and best interest decisions recorded for having bedrails fitted. This placed the person at risk of not receiving care in line with their wishes and best interests.

The provider had not acted in accordance with the requirements of the MCA and was in breach of Regulation 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We found the provider had sent Deprivation of Liberty Safeguards (DoLS) authorisation requests for people who lacked capacity and were waiting for some of these to be authorised by the local authority.

Adapting service, design, and decoration to meet people's needs
● The floor in the dining room had stained patches throughout the surface, some of the wallpaper was peeling. The flooring in the hallway was dirty and stained. We raised these issues with the registered manager, they confirmed there were plans to complete a refurbishment to address these issues.
● The premises provided people with choices about where they spent their time.

● People's rooms were decorated and furnished to meet their personal tastes and preferences, for example having family photographs and artwork.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● People's needs had been individually assessed before they moved into the home. Whilst some information had been used to inform staff about a person's care and support needs, care plans did not always contain all the information needed to provide safe and effective care. People's needs had been assessed prior to starting with the service in line with legislation and guidance. The assessments identified people's needs in relation to issues such as personal care, eating and drinking, mobility, skincare and communication. This information had been used to develop a care plan to support staff to understand how to meet the person's needs. One relative told us, "[Name of person] needs coaching to eat and drink, they do encourage them and they do comply."
●People's protected characteristics, as identified in the Equality Act 2010, were considered as part of their assessments. This included needs in relation to gender, age, culture, religion, ethnicity and disability.

Staff support: induction, training, skills and experience
● People continued to be supported by a staff team who had skills, knowledge and training to carry out their roles. Improvements were required regarding training around health and safety and neglect.
●Relatives told us staff knew what they were doing and were well trained. One relative told us, "The staff do receive relevant training and do follow procedures, the staff are pretty much experienced."
●The provider had systems in place to induct, train and develop staff. A staff member told us, "Their training has improved, you are fully supported by everyone."

Supporting people to eat and drink enough to maintain a balanced diet
●People's care records contained up to date nutrition information for staff to follow.
●People with modified diets had assessments to specify the type of diet they should consume.
●Staff we spoke with knew people's food likes and dislikes and were aware of specific dietary needs and any risks associated with eating and drinking. One relative told us, "[Name of person] needs coaching to eat and drink they do encourage them and they do comply ."

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● The service worked very closely with other agencies and health professionals in order to meet people's specific needs. Care records showed involvement from a range of health care professionals including GP, dentist and optician.
● Staff monitored people's health care needs and would inform relatives, senior staff members and healthcare professionals if there was any change in people's health needs.

Inadequate

Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has changed to inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

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

- Governance systems and processes were not effective to monitor risks to people's care and to ensure care records contained relevant information. For example, one person had been diagnosed with epilepsy; however, a care plan was not in place to help manage this condition. In addition, care records did not describe the nature or frequency of the person's seizures or provide staff with clear guidance on the action they should take in the event of a seizure. Furthermore, there was no seizure log in place or consistent record of the seizures they had had since admission. Care records indicated the person had three seizures over the course of a three-week period. However, there was no evidence a medical review had been arranged following these seizures. A medical review helps to explore if the frequency and nature of a person's seizures have changed and if there are any underlying issues that need to be addressed.
- We found care records were not always completed accurately or clearly to demonstrate safe practice and enable effective monitoring to take place. For example, we found one person's seizures were recorded on an untitled and undated piece of paper in their care records stating that they had seizures with no details of what action had taken place.
- Audits and maintenance checks completed by the provider had not identified the issues we found during the inspection such as unsafe equipment, inconsistent care recordings and care records lacking relevant information about people's health needs. The lack of oversight placed people at risk of harm or neglect, for example new or agency staff members not knowing people needs due to inconsistencies in care records. In addition, staff members not taking appropriate action to ensure people were not neglected. The registered manager showed us a new audit system they were due to implement to improve the effectiveness of the governance and quality monitoring within the home.

Systems and processes to assess and monitor the quality and safety of the service were not robust. This placed people at risk of harm. This was a continued breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities).

- The registered manager and owner were receptive to our recommendations during and after the inspection. They were committed to making improvements throughout the service and had recently commissioned an external agency to support them to make improvements within the home.
- Staff we spoke with were positive about working for the service. One staff member told us, "The registered manager is good and approachable. We all get stuck in and help each other."
- The provider was aware of their legal responsibilities to inform us about significant events which could

occur at the service.
● The management team had contingency arrangements in place to ensure the service delivery was not interrupted by unforeseen events. For example, the COVID-19 pandemic, we saw there were plans in place to ensure care tasks would be completed.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
● People, relatives and all staff we spoke with told us they felt listened to and the provider was approachable. A relative told us, "I'm always in contact with the care home, they regularly communicate with me, if they need to advise me on anything, I am well informed."
● The provider told us they only took on care packages if they could meet people's needs.

Continuous learning and improving care
● The management team ensured they always kept up to date with changing guidance. They also ensured policies had been updated to reflect these changes.
● Staff had completed training and they had access to continued learning however improvements were required in relation training and knowledge regarding neglect and health and safety.

Working in partnership with others
● Staff worked in partnership with health and social care professionals however improvements were required to ensure professional recommendations were completed in a timely manner.
How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong
● The management team understood their responsibilities around the duty of candour. They had a policy and procedure in place. The management team told us they understood their responsibility to be open and honest when things go wrong.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● The management team used feedback from a variety of sources, including involving people and relatives in individual reviews to make sure their care and support was personalised and met people's needs.
● Relatives felt able to speak with staff and management of the home when needed and felt their feedback would be listened to.

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 11 HSCA RA Regulations 2014 Need for consent The provider had failed to ensure the principles of the MCA were followed as people did not always have their capacity assessed for specific decisions and best interests' decisions recorded as required.

The enforcement action we took:

Requirement notice.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Systems had not been established to assess, monitor and mitigate risks to the health, safety and welfare of people using the service This placed people at risk of harm.

The enforcement action we took:

Notice of proposal.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems and processes to assess and monitor the quality and safety of the service were not robust. This placed people at risk of harm.

The enforcement action we took:

Notice of proposal.