Partnerships in Care Limited

Oak House

Inspection report

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Diss
Norfolk
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Website: www.prioryadultcare.co.uk/find-a-location/oak-house/

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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?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Oak house is a residential home providing personal and nursing care to seven people living with autism, learning disability or other sensory impairment. At the time of our inspection there were three people using the service all under 65.

Oak house is an adapted building providing single bedrooms on ground and first floor, some include a kitchen and lounge. There is also a shared lounge/dining room and kitchen. There was an enclosed garden and easy access to town.

The service had not been developed and designed in line with the principles and values that underpin Registering the Right Support and other best practice guidance. This would have ensured that people who use the service can live as full a life as possible and achieve the best possible outcomes. The principles reflect the need for people with learning disabilities and/or autism to live meaningful lives that include control, choice, and independence. People using the service did not receive a sufficiently planned and co-ordinated person-centred support that is appropriate and inclusive for them.

The building design was appropriate. There were deliberately no identifying signs, intercom, cameras, industrial bins or anything else outside to indicate it was a care home. Staff were also discouraged from wearing anything that suggested they were care staff when coming and going with people.

People's experience of using this service and what we found

The three people using the service at the time of our inspection had very different needs which required one to one staff support. We had concerns that people's care records were not sufficiently robust or for one person make it clear how their needs were clearly being met. Their care plan did not include a clear transitional plan when transferring from hospital to care home and there was poor evidence of how they were being supported to develop their skills and confidence.

People's needs were not sufficiently well managed. Records did not show how changes in need were quickly identified and there was insufficient action to mitigate risk. People were at risk from self -inflicted behaviours or challenging behaviours from others and staff were not sufficiently equipped to deal with people's behaviour. This resulted in incidents which could have been avoidable and self -neglect which went unchallenged.

People had been assessed as needing a minimum of one to one staffing and in certain situation two to one staffing. Staffing levels were being maintained but records did not provide evidence that people had lots of opportunity to engage in activity in and out of the service. We did not see regular, planned activity for people to develop their confidence, self-esteem and independence.

Team work was not good with some staff having a poor attitude to their job. The service objective talked of creating a calm, therapeutic atmosphere for people. This is not what we observed. Some staff did not demonstrate the right attitude or demonstrate how they could adapt their practice to working in a community care setting. Not all staff were following procedures or reporting incidents in line with operating procedures. This in effect meant incidents were not appropriately managed. The new manager of the service was aware of issues amongst the staff team and was addressing these with support from operational staff and human resources. We had concerns that their records did not show how these performance issues were being addressed but were reassured that the provider was taking action through their human resources department.

Since registration there had been three changes in manager, including a peripatetic manager which had impacted on the stability of the service and had meant that staff had not had clear leadership and direction. The new manager had been in post a month, the deputy manager a week. They were making some inroads in terms of service improvements and there was a clear action plan in place. Despite these improvements there had been a number of significant incidents in the week leading up to the inspection where people had suffered harm which could have been avoided if staff worked consistently and in line with best practice.

Rating at last inspection
This service was registered with us on 25 May 2018 and this is the first inspection.

Why we inspected
This was a planned inspection carried out according to our methodology. We have found evidence that the provider needs to make improvements. Please see the relevant key question sections of this full report. You can see what action we have asked the provider to take at the end of this full report.

Enforcement
We have identified five breaches in relation to the safety of people using the service as a direct result of poor management and oversight and staff not having the necessary skills and competences. People were not receiving a service around their assessed needs and preferences in the least restrictive way.

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.

In response to this inspection CQC took some actions against the provider to help ensure the service continued to make the improvements necessary.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service effective?

Requires Improvement

The service was not always effective.

Details are in our effective findings below.

Is the service caring?

Requires Improvement

The service was not always caring.

Details are in our caring findings below.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Details are in our responsive findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-Led findings below.

Oak House

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. 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.

Inspection team
The inspection was carried out by one inspector.

Service and service type
Oak Houses 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 service had a manager who was not yet registered with the Care Quality Commission but was in the process of registering. This will mean that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We contacted two local authorities who commissioned the service, one of which raised some concerns they had about the service. We considered any other information received from and about the service including notifications which are important events the service is required to tell us about. 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 this information to plan our inspection.

During the inspection-

Most people using the service were either not able or did not want to provide verbal feedback on the service. We spoke with one person and one relative. We also spoke with the quality assurance officer from Norfolk county council who was there to reviews a person's care. We spoke with the manager, regional manager, operational director and quality manager. We also spoke with the deputy manager and a member of the care team. We met with the staff team and sat in their staff meeting with the permission of the manager. We reviewed one person's record and looked at other records relating to the management and oversight of the service.

We carried out observations of the care provided although this was minimal due to people living in separate self-contained accommodation and not wanting to interact with us at the time of our inspection.

After the inspection –
We continued to seek clarification from the provider to validate evidence found and received feedback from the provider and local authority.

Inadequate

Is the service safe?

Our findings

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

Inadequate: This meant people were not safe and were at risk of avoidable harm.

Systems and processes to safeguard people from the risk of abuse and assessing risk, safety monitoring and management

● Staff did not always adhere to policies and guidance in relation to reporting and documenting safeguarding incidents. The manager expressed concern during discussion with staff on the day of our inspection that some staff were not following behaviour protocol or incident reporting guidance. This had meant the management team could not always take timely action or have sufficient oversight of people's care and treatment. Following the inspection visit, the police met the manager at the service and discussed numerous incidents where they had been called to the service. The police expressed concern about how their resources were being used and said some of these incidents could have been deescalated and managed by the staff team

●We found concerns regarding the management of behaviours that may challenge. There was conflicting information regarding the use of restraint in the service. Staff told us they did not feel confident in managing risks associated with these behaviours. This resulted in staff calling the police which had a negative impact on people as it escalated people's anxiety and increased the likely severity of the incident.

● We were not confident that staff used the least restrictive approach when supporting people with their anxiety and negative behaviours. In the information sent to us, (PIR) it stated restraint had been used on two separate occasions. The current manager said this was not the case and staff had been trained to support people using non-confrontational techniques designed to deescalate people's behaviour. Staff told us the techniques did not work and they felt unsafe when using these techniques and said they felt some people's needs outweighed what the service could provide.

● The statement of purpose for the service said they could accommodate people with a learning disability or a mental health need. It stated they were commissioned by the local authority to provide a service to people with challenging behaviour, autism, or other complex needs including learning disabilities. The service could not evidence how they were suitably specialised and equipped their staff to manage people's complex needs which included offending behaviours, poor mental health and behaviours such as self-neglect and self-harm which required specialist interventions and therapeutic support. The service employed a positive behaviour support practitioner to support staff but not all staff yet felt confident in supporting people with their needs.

● Training was provided to support staff to manage behaviours which might challenge but staff felt this was inadequate, had not been provided in a timely way and there was insufficient supervision of staff practice. Staff said the manager had not yet worked alongside them so had no appreciation of the level of aggression, some unprovoked, that they were expected to manage.

● Guidance in people's care plans was not specific enough in relation to risk and support people needed in line with their needs. For example, the risks associated with self-neglect and poor decision making. This meant people were not always receiving the support they needed in respect to their health and welfare and had experienced significant health issues. For one person not all of the risks of injury from self- harming had

been sufficiently mitigated.
●We looked at one person's record in respect to their diet and found staff were not regularly recording their weight or recording if they refused. The person often made unwise dietary choices as evidenced from their food diary. There was no evidence that the staff tried to support the person either to lose weight or to help them reduce their risk from developing long term health conditions. Referral to speech and language therapists were not evidenced despite some issues with swallowing. This meant the risk of avoidable harm had not been reduced.

Failure to assess and mitigate risks adequately was a breach of regulation 12 of The Health and Social Care Act 2008 (regulated Activities) Regulations 2014.

Staffing and recruitment
●The management team had recognised that the current staff shift patterns were not conducive to meeting people's needs as staff worked set shift patterns which were not flexible and did not ensure staff worked cohesively as one team.
●Different teams had established different ways of working which were not in the best interest of people using the service.
●Staffing levels were high to ensure people's needs could be met. Staffing ratios were a minimum of one to one and at times two to one.
● Employment checks, such as references, were carried out to check the suitability of staff prior to working in the service. However, staff interviews did not always explore and establish if staff had the right values, skills, and approach to work in the service.

Using medicines safely
●Regular audits of people's medicines had been carried out. A number of gaps in people's medicine administration records had been identified. The manager had acted to investigate these and establish if people had received their medicines as required.
● Senior staff had received training to administer medicines. Competency checks were carried out to assess if staff were able to administer medicines safely. We felt however that the processes were not sufficiently robust as some staff only had one observation of practice recorded and this did not consider the different administration times with more medicines required at different times of day.
● Sufficient guidance was not in place for one person who had 'as required' medicines prescribed, and we were not confident that staff would know when to administer this medicine if needed.

Preventing and controlling infection
● Staff supported people to maintain their hygiene and a clean environment.
● A number of people struggled with this and staff demonstrated a poor attitude in relation to supporting people with their personal care.

●Staff received training in infection control and were provided with personal protective equipment but not all staff felt they were sufficiently protected from infection and raised concerns about infection control. Protective clothing did not include foot ware which some staff felt they needed when supporting people to shower. Without this equipment staff were reluctant to support people with aspects of their personal care.
● Audits were in place to identify any issues with maintenance or cleanliness. On the day of inspection some deep cleaning was taking place.

Learning lessons when things go wrong
● Whilst systems had been introduced to monitor and assess incidents that occurred in the service the

effectiveness of this system was impaired because staff were not always identifying or reporting incidents.

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.

Requires Improvement: This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

- Guidance in place did not reflect current guidance and best practice. It was not clear if the service had consulted relevant professionals to ensure their guidance was appropriate. Some guidance was not dated and there was no evidence it had been shared to ensure staff were aware of it and had adopted it as part of their working practice.
- Assessments were collated from other health care professionals but there were no clear transitional plans on admission to the service clearly identifying goals and objectives in line with the statement of purpose and service objectives.
- A family member told us they were not clear what was being commissioned or what service their family member was meant to be receiving in line with their assessed needs.

Staff support: induction, training, skills and experience

- Staff told us they felt they needed more support and training in relation to people's complex mental health needs and associated behaviours. Several staff told us the provider's training in this area was not enough.
- The provider had systems in place to ensure staff received adequate induction and regular supervision of their practice but had failed to record these accurately for some staff where there were performance issues.
- The provider had not ensured that staff have transferable skills when transferring from hospital to community setting. This had resulted in staff supporting people in a way which was not appropriate to their needs. Staff demonstrated a poor understanding of how to support people with poor mental health and dual diagnosis.

Failure to adequately train and support staff to carry out the regulated activity in line with people's assessed needs is a breach of regulation 18 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to eat and drink enough to maintain a balanced diet

- Not all risks associated with people dietary needs had been identified or clearly acted upon in relation to dietary intake and ensuring a healthy and balanced diet, or risks associated with aspiration.
- People were supported with their meal preparation and dietary needs. Staff were observed cooking for people and people could access the kitchen and be involved in food preparation. A record of people's dietary intake was kept so staff could monitor what people ate.

Staff working with other agencies to provide consistent, effective, timely care and supporting people to live healthier lives, access healthcare services and support.

●The service had not always responded in a timely way to ensure people's health care needs were met. For example, a person's walking frame had been broken for more than two weeks which would impact on their mobility. A referral to the speech and language team had not been made in a timely way despite a person being identified as having swallowing difficulties and a poor diet. This meant staff did not have clear advice to follow to ensure the person was safely supported. The condition of their feet had not been sufficiently addressed and there was no clear evidence that staff encouraged the person to adopt a healthier lifestyle or to understand the risks of them not doing so.

● People's mental health was poorly understood, one person's records documented that they became anxious when visiting health care professionals. On the morning of the inspection their routines were changed to take them to the surgery. This was not properly communicated or planned. Their care plan did not consider how staff should prepare a person for forthcoming appointments and what staff could do to reduce the persons anxiety. There was no guidance to help the person self-regulate their emotions.

Adapting service, design, decoration to meet people's needs

●The service provided flexible, individual accommodation which was designed to reduce risk to people living at the service. For example, in people's rooms radiators did not expose people to the risk of scalding, taps were designed to be operated easily, items of furniture such as televisions were secured and boxed in, so they could not be thrown or broken.

● Not all risks were appropriately managed and there had been a number of incidents one in which glass and other items had been broken and used as a weapon or for self-harm. Internal doors including the kitchen had been kept locked and restricted people's access without a clear rationale established. This had been identified and was being addressed by the provider.

Ensuring consent to care and treatment in line with law and guidance

The Mental Capacity Act 2005 (MCA) provides a legal framework for making 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 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, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS.

● At the time of our inspection no one was deprived of their liberty. One person sometimes left the service when in a heightened state of anxiety and staff expressed concern about their safety and the safety of others. when they did this. The service had referred this to their social worker.

● Mental capacity assessments were reviewed for one person but these only covered consent to care and support with finance. The person did not always consent to care and was at risk of self-neglect. This had not been considered in line with their level of capacity and their ability to understand more complex decisions or retain information.

●Practices within the service were not always the least restrictive or based on an individualised approach to care. There were examples of people self-harming, and, or assaulting others but these incidents had not always been managed in a proportionate, appropriate way.

This represented a breach of regulation 11 of The Health and Social Care Act 2008 (regulated Activities) Regulations 2014.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.
Requires improvement: This meant people did not always feel well-supported, cared for or treated with dignity and respect.
Ensuring people are well treated and supported; respecting equality and diversity
● Staff expressed concern about supporting people around their specific personal care needs and implied they were not happy to do so. This meant we could not be fully assured people received the care they needed
●Where people had expressed a preference of the gender of staff they wished to support them this was respected but not recorded as part of their plan of care People were not always able to have an input as who they would like to support them or be involved in staff recruitment and selection which would enabled them to influence decisions taken by the manager.
● In the short time the service had been operational divisions amongst the staff team had become apparent with staff working set shift patterns and not working as part of a larger team. This impacted on people's support and did not ensure people received consistency of support as each shift had developed its own culture.
●There were tensions between some staff and the management and staff were not working as expected. This meant we were not assured that staff practice was appropriate or in line with company policy. It also meant the service was not person centred.

Supporting people to express their views and be involved in making decisions about their care
● Advocacy had not been sought for people as appropriate to support people to make life choices, particularly where people did not have regular input from families.
● People were able to comment on the service they received. Reviews had been held with them and other health care professionals to discuss any concerns or issues. Some people had however declined and had chosen not to comment, and it was not clear from records how the service tried continuously to engage with people or provide support to enable people to communicate their needs and wishes.

Respecting and promoting people's privacy, dignity and independence
● Clear objectives were not in place, so we could not monitor what progress people were making towards increased independence.
● Transition plans to support people moving from one setting to another were not in place.
● Care plans were not specific in terms of how people's privacy, dignity and independence should be upheld or how care and support should be centred around their preferences and abilities.

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

Requires improvement: This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

●Care and support plans lacked clarity as they did not contain specific guidance in relation to meeting people's preferences, routines and goals. This was despite the service having clear objectives which were not reflected in in practice.

● care plans were not put in place in a timely way or reviewed regularly clearly showing how objectives identified were achieved.

●Daily notes were generic and did not give a descriptive account of how the persons needs had been met in line with their plan of care. This meant we could not see how staff would identify changes in a timely way or ensure they took appropriate actions to address unmet need.

Meeting people's communication needs

Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

● People had a number of sensory needs including hearing impairment and sensory processing issues which needed to be taken into account when supporting people.

● Communication plans were not in place and communication aids were not used. We asked staff how people knew what they were doing daily. Staff said for one person we would 'write it on a bit of paper.' There were no picture boards, apps or personal diaries to support people.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

●Records provided limited evidence that people had regular opportunity to engage in activities they enjoyed in and out of the service

● A number of people had poor mental health and lacked motivation but in the absence of regularly planned activity it was difficult to assess how staff were promoting positive mental and physical health.

● Staff described activities as 'adhoc'. A parent was concerned that their family member did not do much during the day although staff had initiated that they go to the gym regularly. The family member had contacted a college to help their relative access higher education

Failure to meet people's individual needs in line with their preferences was a breach of Regulation 9 of The Health and Social Care Act 2008 (regulated Activities) Regulations 2014.

Improving care quality in response to complaints or concerns

● There was an established complaints procedure which was accessible. The only recorded complaint had been appropriately responded to within the given timescales.

End of life care and support

●The service was designed to provide short term care. The care and support plan reviewed did not include details of people's preferences in relation to end of life care and no advance care plans were in place.

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.

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

●This was the first inspection since we registered the service. Whilst the provider had started to take action to make improvements we had such serious concerns about the safety and welfare of people using the service that we issued a Notice of Decision requiring the provider to send us information on a regular basis. This will remain in place until the provider can satisfy us that they have taken all necessary steps to ensure the safety of people using the service and have stabilised the service provided. We also sought assurances that staff performing below expectation would be supported to improve their practice or dismissed if they failed to make improvement.

● We did not have sufficient confidence in the provider given that since registration the service had failed to deliver good care or identify in a timely way short falls in their service provision as a result of poor governance and oversight.

● The service has had a number of different managers both on a temporary and permanent basis. They have failed to provide continuity and consistency and poor leadership enabled a poor culture to develop. People have suffered from a poor organisational culture which has meant breaches of regulation and unmet need.

● The provider had failed to ensure staff understood and followed the service's policies and procedures. This had a far-reaching impact on the care and support people received. For example, risks were not appropriately identified and managed and people did not get care in line with their assessed needs. Incidents were not reported in a timely way or dealt with appropriately which meant that the manager had not always taken timely action and lessons learnt were not firmly embedded in the service.

● There was a lack of oversight and action by the provider to assure themselves that staff were competent and able to undertake their role. This had impacted on the quality of the service provided.

● The provider had failed to ensure people's care records were contemporaneous. They did not evidence how the service was meeting people's care needs and were not accurate.

● The provider had failed to take timely action to address concerns and ensure people had good outcomes.

● The service's statement of purpose was not up to date and did not demonstrate how the service would meet the needs of people currently using the service in respect to their mental health and associated behaviours.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people and working with others

● The service was not conducive to the wellbeing of people using the service or the staff and did not achieve good outcomes for those using the service. There was a poor working culture, and not all staff were working

as part of a team or following instruction and guidance provided.
●The service objectives were very specific about what they could provide in line with people's assessed needs. We found however peoples care and support plans had not been developed in line with people's assessed needs. The statement of purpose and service objectives did not make it sufficiently explicit how it was going to meet people's needs or the scope of the service to do so.
● Staff did not demonstrate the values and behaviour of the organisation. A poor culture had developed and although a new manager and deputy manager had been brought into post some staff were not willing to work as directed. Staff recruitment, training and induction had not been sufficiently robust or helped to ensure all staff had the right skills and values to carry out their role in line with the regulated activity.
● The service referred to other agencies for advice, but this was not reflected in the guidance for staff particularly around managing behaviours which had a negative impact on people using the service or others.
● People were consulted about their care but not all wanted to contribute to this process. There was limited evidence of who else had been involved or could act on behalf of others, including advocacy services.
● There was limited engagement with the wider public and resources which could enhance people's independence.
Failure to assess, monitor and improve the quality of the service and maintain appropriate and contemporaneous records and robust care plans was a breach of Regulation 17 of The Health and Social Care Act 2008 (regulated Activities) Regulations 2014.

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
●Actions were being taken to address the staff culture prior to the inspection and the service was working with the Local Authority to improve outcomes for people. We however felt that further improvements were needed to evidence how the service was being effectively managed in line with its own objectives.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● The service had not taken people's individual protected needs and other issues in to account when consulting with those who used the service. The service had not considered how they could consult with additional people, such as relatives and other stakeholders, to help them monitor and improve the quality of the service.

Continuous learning and improving care
●The provider had not demonstrated how they continuously learn and develop the service in line with people's experiences and expectations or how they consulted with others to develop best practice.