Osei Minkah Care Limited

Oak Cottage

Inspection report

Oak Cottage Oak Street
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Wolverhampton
West Midlands
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Tel: 01902681235

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Oak Cottage is a care home that provides personal care and accommodation for up to five children between the age of 13 to 17 or younger adults who may have a learning disability, autistic spectrum disorder or mental health needs. There were three children living at the home at the time of our inspection.

The service was a large domestic size home. There was little in the way of identifying the home was anything other than a domestic property. Staff did not wear anything that suggested they were care staff when coming and going with children. Children shared communal areas, but all had separate bedrooms, some with ensuite facilities.

The provider is also registered to provide personal care to people that use supported living. None of the people using the supported living were receiving personal care at the time of our inspection. CQC only inspects these services where people receive personal care. This is help with tasks related to personal hygiene and eating. Where they do we also consider any wider social care provided.

People's experience of using this service and what we found
The provider's management of the service was reactive, and although there was evidence of some positive changes recently, these were mostly driven by the findings from another regulator that had inspected the service prior to our inspection. The provider needed to improve their systems of governance and self-audit so changes to the service are proactive and planned.

There were occasions where some staff had not adhered to boundaries identified to keep children safe.

Young people's medicines were not always recorded accurately meaning it was not always possible to confirm if a young person had taken their medicines and the reasons for this.

Staffing levels reflected those needed to provide for young people's safety although there had been a period where numerous agency staff were employed to maintain staff numbers. The provider was recruiting staff, in a safe way, to ensure their reliance on agency staff was reduced and better consistency of care maintained.

The provider's process for admitting people to the service did need review and care did need to be taken to ensure a person's admission was safe. In addition, the impact on other people who lived at the home and the anxiety moving to the home would present to a person needed consideration.

The home's environment did not present as that within a family home, as many items had been removed due to the risk of damage, although work was been taken to repair areas of damage as quickly as possible.

Staff understood safeguarding processes related to children and adults and knew how to raise concerns and who to. The provider had kept CQC informed of any allegations of abuse or incidents where younger people

may be at risk.

Staff were knowledgeable about children and what may make them anxious, and how they should respond to reduce this anxiety.

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 good (last report published 19/03/2019)

Why we inspected
The inspection was prompted in part due to concerns received about the safety and management of the service following inspection by another regulator.

We received concerns in relation to the safety of young people using the service. This had triggered an inspection by OFSTED, as the care home is also registered as a children's home.

We reviewed the information we held about the service. Areas of concern identified related to safety and management. We therefore inspected to look at the domains safe and well led. Ratings from previous comprehensive inspections for those Key Questions were used in calculating the overall rating at this inspection.

The overall rating for the service has changed from good to requires improvement. This is based on the findings at this inspection.

We have found evidence that the provider needs to make improvement. Please see the safe and well led sections of this report.

You can see what action we have asked the provider to take at the end of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Oak Cottage on our website at www.cqc.org.uk.

Enforcement
We have identified breaches in relation to some elements of the management of the service.

Please see the action we have told the provider to take at the end of this report.

Follow up

We will continue to monitor information we receive about the service until we return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

We will request an action plan for the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.
Details are in our safe findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.
Details are in our well-Led findings below.

Oak Cottage

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 completed by two inspectors on the first visit and one on the second.

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

This service also provides care and support to people living in 'supported living', so that they can live as independently as possible. People's care and housing are provided under separate contractual agreements. CQC does not regulate premises used for supported living; this inspection did not look at people's personal care and support as no one was receiving personal care at the time of the inspection.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced on our first visit and announced on our second.

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. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they

plan to make. We took this into account when we inspected the service and made the judgements in this report. We used all this information to plan our inspection.

During the inspection
We spoke with one person who used the service. We spoke with five members of staff including the deputy manager, senior care workers and care workers.

We reviewed a range of records. This included two young people's care records and medication records. We looked at four staff files in relation to recruitment and staff supervision. We also reviewed several records relating to the management of the service, including policies and procedures. We spoke with seven professionals who have were involved with people living at the service. Between, and following our visits our visits we spoke with several health care professionals, for example social workers.

After the inspection
We continued to seek clarification from the provider to validate evidence found.

Requires Improvement

Is the service safe?

Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement.

This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Assessing risk, safety monitoring and management

● Staff were aware of information contained within risk assessments, although on our first visit we saw a member of staff did not follow the risk assessment when they responded to a young person's anxiety. Whilst the child had not been put at risk the restraint used would have been ineffective and put the staff member at risk. The deputy manager evidenced they had addressed this matter prior to our second visit. Other staff spoken with demonstrated their knowledge of, and ability to use, appropriate and recognised methods to protect children by use of safe methods of behaviour management.

● From review of recent incidents, the number of occasions restraint was used (to prevent children harming themselves or staff) had decreased, and the length of these interventions overall was shorter. The number of staff supporting one child had also positively reduced from six to three staff within a month due to an identified reduction in risk.

●Staff understood the need to acknowledge children's right to take risks, and how these should be minimised by adherence to people's risk assessments.

● A professional we spoke with also told us some staff were not putting clear boundaries in place to protect younger people and this raised their concerns about safety. A member of staff told us one potential trigger for children was staff not adhering to identified boundaries. They said, "We do have meetings where we discuss boundaries for younger people, but it needs to be recorded better, and some staff need to look at messages to make sure they are aware of them". They said this had been raised with the wider staff team.

Using medicines safely

● There was scope for improvement in how medicines were recorded. Handwritten entries of medications prescribed on Medication administration records (MARS) were not always verified as correct by two staff signatures.

● One MARS sheet was completed in a way which meant the records of administration were not dated correctly.

● There were some gaps in MARS sheets, so it was not always possible to verify if a child had received their medicines, or the reason why. Audits seen did not always show why these gaps were present.

● Staff had received medicines training and competency checks.

● Children's medicines were stored safely, and controlled drugs records balanced with the stock of medicines.

● Staff told us, and professionals confirmed that they contacted health care professionals for advice about medicines, and there were regular reviews of medicines. One professional told us staff were, "Managing really well" with a younger person who would sometimes chose not to take their medicines.

Systems and processes to safeguard people from the risk of abuse

● The views of professionals we spoke with as to children's safety were mostly positive, and they told us from recent discussion with children they were involved with that they felt safe at Oak Cottage. One professional told us, "I believe there are systems in place to ensure that risks to people are identified and minimised as far as possible".

● The deputy manager and staff understood safeguarding processes related to children and adults and were able to tell us how they would raise concerns should this be necessary. A member of staff told us, "If there were any disclosures to me (from people), I would contact the relevant people".

● The provider had informed CQC of any safeguarding allegations or concerns promptly prior to our inspection. Many of the professionals we spoke with said the provider worked work with them when concerns were identified to keep people safe.

Staffing and recruitment

● Due to a recent admission the provider had needed to increase staffing levels. The provider had failed to identify the exact staffing requirement prior to the child's admission, which had led to the provider using several agency staff to maintain safe staffing levels. The provider had however ensured staffing levels were maintained at the levels required as set out in the children's dependency assessments.

● The deputy manager told us how they had, wherever possible, used the same agency staff to promote consistency and were recruiting new staff. At the time of our second visit the number of agency staff used had decreased, with more permanent staff in place. A member of staff told us,
"Use of agency staff was not helpful when working three to one (young person) but its better now with permanent staff for consistency."

● Staff had been recruited safely. All pre-employment checks had been carried out including Disclosure and Barring Service (DBS) checks, this applied to the adult and children's barring list.

Preventing and controlling infection

● Staff were knowledgeable about protecting people from the risk of infection, for example, by use of disposable gloves and aprons when required.

● The home had been awarded a five-star food hygiene rating by the Food Standards Agency.

Learning lessons when things go wrong

● The deputy manager told us the last admission to the home had been on an emergency basis although there had been issues with the information that was provided prior to admission as the staffing ratio had been different to that expected. The level of anxiety experienced by the child during the weeks after admission, highlighted the need for an improved admissions process that ensured people were safe at a time of potentially elevated anxiety. The deputy told us admissions would only be agreed by themselves and the registered manager but when requested after our second visit an updated admissions process was not made available to us.

● The provider had made some positive changes recently, for example incident forms had been revised. These forms now showed details about incidents in a way which showed what was learnt by the management and what should be considered in respect of similar incidents and whether there were any trends to consider.

● These changes were however in part driven by the findings from another regulator, and whilst it was positive changes were being made, they had not always been identified by the provider.

Requires Improvement

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 good. At this inspection this key question has now deteriorated to requires improvement.

This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

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

- The service had a manager registered with CQC and one registered with OFSTED. At our inspection we were involved with the deputy manager who was the OFSTED registered manager. The CQC registered manager was not present during our inspection. Following discussion with the deputy manager, staff and professionals it was apparent the deputy manager was responsible for the day to day running of the service.
- The deputy manager's time for management of the oversight of the service had been restricted recently as events had meant management was reactive, rather than planned. For example, action plans were mainly based on the findings from other regulators rather than those identified by the provider.
- The deputy manager told us the provider had identified staff from the organisation to undertake more of the governance and quality monitoring work, to improve the provider's oversight of the service. They said this work had commenced, although revised improvement plans the deputy said would be sent to us post inspection had not been received at the time this report was written.
- Some quality monitoring arrangements were in place, but these were not always effective enough to give the provider oversight of where there was a need for improvement, for example, systems in place had failed to identify errors in medication management that were found during the inspection
- There had been numerous incidents in the last three months where a child had damaged the fixtures and fittings in the home. Repairs were being made as quickly as possible, although these were in response to the damage, with no plan to ensure improvements were planned to fit fixtures that were more resistant to future damage.
- The response of the provider to remove risks to younger people had been to remove many items of furniture that meant the environment was not representative of a family home. A professional told us, "The building is in a bad state, it was completely trashed on last visit before Christmas all conservatory windows smashed [on our last inspection visit these had been replaced]. This was not the case when [the child] was first admitted. Time before there were TVs and it was homelier". In addition, the radiator surfaces were very hot to the touch and could potentially present some risk. This needed to be considered in the provider's environmental audits.
- The provider had ensured we were notified of events as required by regulation. We saw the previous CQC inspection rating was displayed at the home but not on the provider's website at the time of our inspection. While the rating was displayed on the website a few days this showed the provider had not been aware of this requirement prior to it been raised by us.

Continuous learning and improving care

● Despite a poorly planned admission of a child to the home last year, the provider had not formally reviewed their admissions procedure to ensure changes the deputy had discussed with us were formally adopted. For example, at what level decisions about any admission could be made. We asked the deputy manager to forward a revised copy of the admissions procedure that showed these revisions post inspection, but at the time of writing this report, this information has not been received.

● There was evidence of work to improve systems, for example an electronic records system was being introduced, which staff were positive about. The deputy manager explained they were transitioning between the electronic and paper records. This made access to them more difficult on occasion. For example, when a copy of the current staff rota was requested, the printed copy did not reflect the staff on duty that day, as not all the staff present were detailed on the printed rota. This transition could have been better planned.

●Recent inspections by OFSTED had identified numerous failings and breaches of Children's home regulations. The provider's improvement action planning demonstrated a reactive approach to these findings, and not a proactive and planned approach. While there was evidence of some improvement in response to their findings, further improvement to ensure children, who lived at the service receive safe and high-quality care is needed.

Due to a lack of robust oversight of the service people who lived at the home were placed at potential risk of harm. This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Promoting person-centred, high-quality care and support; and how the provider understands and acts on duty of candour responsibility

● Staff we spoke with understood the need to be open and candid with children about why they may, for example apply restrictions for safety reasons. The deputy manager and staff were also open about the current challenges the service faced.

● Professionals who worked with children at Oak Cottage gave us a positive picture of the care provided. Their comments included, "Placement at Oak Cottage is far better than previous placement" and "The care is very good. They get [the child] and they can be very flexible - they relate to [child's name] well and it's the first time they have been settled."

● Professionals told us children they visited had not expressed any concerns about their safety beyond a comment about one of the other children damaging the home's property and structure. One professional told us a child had described Oak Cottage as 'Great, it's sound'. Another professional commented more matching of people's personalities would have been better during any admission.

● Professionals made comment about where improvements could be made. One told us, "There have been some concerns about the organisation regarding feeding back as well as needed but social workers have been visiting. Record keeping needs to be better".

● Staff told us about the provider's whistleblowing policy and said they knew how to use it to raise concerns if necessary. All staff we spoke with said they found the deputy and registered manager approachable should they have any concerns.

● The deputy manager was aware of their responsibilities under their duty of candour and were open and honest about areas where they felt the service needed to improve. They recognised and discussed with us where improvements were needed, the challenges the service currently faced and how the provider planned to respond to these challenges.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

● There were systems in place to engage with children. This included regular reviews with professionals, use of independent visitors (as required by the Children's home regulations) and on-going day to day contact.
● Survey forms had been used to gain younger people's views of the service, the last completed in October 2019. Comments were generally positive with one younger person writing, 'It's alright and I enjoy communicating with staff'. They added staff listened (sometimes) and there was a good mix of male and female staff.
● Staff we spoke with were positive about the support they received from the management team. A member of staff said, "I feel confident other staff are always on hand, [the registered manager] at communication house [provider's office] is approachable. [The deputy] has her finger on pulse, she has all the answers. They are supportive." No staff had any qualms about approaching managers for support.
● Staff we spoke with were well informed as to children's equality characteristics and were able to tell us how they considered these when supporting children.

Working in partnership with others
● The registered manager and staff told us how they worked closely with other health care professionals to promote joined up care between themselves and other services, for example, the staff had good contacts with social work and health care teams.
● The majority of professionals we spoke with confirmed staff at the home worked with them, would contact them for advice and follow recommendations they gave. One professional told us, "Oak Cottage's communication with us is good and they will engage. They will contact us if there are any issues."

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Due to a lack of robust oversight of the service people who lived at the home were placed at potential risk of harm. The provider must ensure there are consistent systems and processes that are operated effectively to ensure people receive safe care. Regulation 17 (1) and (2)