Camino Healthcare Limited

Oak House

Inspection report

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04 June 2019

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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 care home providing personal and nursing care to people who may have learning disabilities or care needs relating to their mental health. The service can support up to 16 people. We inspected this service on four dates between 15 May and 4 June 2019. On the first two days of inspection, there were 13 people living at Oak House. On the third day of inspection, there were 12 people receiving support from the service and on the fourth day of inspection, there were eight people receiving support.

The service has been developed and designed in line with the principles and values that underpin Registering the Right Support and other best practice guidance. This ensures 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 were not safeguarded from abuse as allegations of abuse were not always investigated or referred to external agencies. Risks to people were not consistently well managed and left people at risk of harm. People's individual needs had not always been met by the right number of staff with the required competencies and skills.

Staff had not received the training and support they needed to support people effectively.
People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice. Timely action had not been taken where people had gained significant weight. People's access to the provider's in-house therapy team had been inconsistent.

People were supported by staff who were caring, but the provider's systems and processes did not support them to consistently display their caring values. People were given some choices but did not consistently involve people in decisions around their care. People were not always treated with dignity.

People were supported by staff who knew them well. However, this knowledge of people's likes and dislikes had not been reflected in care records. People had access to activities, but these had previously been restricted due to the numbers of staff available for people. People's concerns were not always acted upon.

The systems and processes in place had not supported the provider to identify where areas for improvement were needed. This meant that risks to people's safety or incidents that left people at risk of harm were not identified or acted on by the provider. People and staff's concerns about the service had not been acted upon. The provider had not acted on their duty of candour and shared information where incidents had occurred.

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 (Published 01 November 2017)

Why we inspected
The inspection was prompted in part by notification of a specific incident in which a person using the service died. This incident is currently subject to an investigation. As a result, this inspection did not examine the circumstances of the incident.

The information CQC received about the incident, indicated concerns about the management of risks to people's health and safety. This inspection examined those risks.

We have found evidence that the provider needs to make improvements. Please see the 'Is the service Safe?' 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 breaches in relation to keeping people safe, responding to allegations of abuse, supporting people in line with the Mental Capacity Act and monitoring the care provided at this inspection.

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 return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

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 caring? The service was not always caring. Details are in our caring findings below.	**Requires Improvement**
Is the service responsive? The service was not always responsive. Details are in our responsive 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 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 team for the first three days of inspection on 15, 16 and 21 May 2019 consisted of three inspectors, a Specialist Advisor who was a Registered Nurse specialising in Mental Health and an 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.

A fourth day of inspection took place on 04 June 2019, the inspection team for this day consisted of two inspectors, an inspection manager and a Specialist Advisor who was a registered Nurse.

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

The service did not have a manager registered with the Care Quality Commission. The service had not had a registered manager since July 2017.

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 external 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 five people who used the service. We also spoke with one nurse, three members of care staff, the occupational therapist, the interim manager and the nominated individual.

We reviewed a range of records. This included 10 people's care records and multiple medication records. We looked at two staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including quality assurance audits, incident records, environmental risk assessments and policies and procedures were reviewed.

After the inspection –
We continued to seek clarification from the provider to validate evidence found. We spoke with professionals from the funding authorities who had visited the service to gain their feedback on whether people were safe and well.

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 Good. At this inspection this key question has now deteriorated to 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

- People had not been safeguarded from abuse. Where people had made serious allegations of abuse against others, these had not been investigated or referred to local authority safeguarding teams. We found incident records that evidenced people had access to illegal drugs within the service and had also made allegations of sexual assaults. None of these had been reported or investigated. We raised these allegations with the interim management team. They were not always aware that allegations of abuse had been made and had not taken action to safeguard people.
- Although staff had received training in safeguarding people, where incidents occurred, staff were not aware of safeguarding procedures they should follow to ensure people's safety. In the action plan sent to us following the first two days of the inspection, the provider confirmed that staff lacked knowledge of how to report and refer concerns of abuse.
- Following the inspection, the provider reviewed incident records from the previous 12 months and informed us of 53 safeguarding incidents that had not been reported. The provider informed us they would be implementing new systems to ensure future concerns would be identified and investigated by a management team.

The lack of systems to identify, report and investigate allegations had left people exposed to potential abuse and meant people were at significant risk of harm. This is a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Assessing risk, safety monitoring and management / Learning lessons when things go wrong

- Risks to people's safety had not been assessed. During the first two days of inspection, we identified a number of key risks to people that had not been assessed or recorded within care records. This included risk of self-harm. For example, incident records showed that a person had recently self-harmed and attempted suffocation. There was no record of this within the person's care records identifying how staff should support the person to remain safe.
- Where risks had been recorded, there was no clear guidance informing staff of the action they should take to ensure people's safety. Where people had a history of self-harm and required support to manage this risk, this was not clearly recorded. For example, where people required supervision around sharp items such as razor blades, this was not recorded to ensure that all staff were aware. Although staff we spoke to were aware of this risk, the number of temporary staff being used at the service meant that these risks may not have been known consistently by staff providing the person's support.
- Following the first two days of inspection, the provider began to implement new risk assessments that would identify the key risks to people's safety. We reviewed these on day three and four of inspection and

found that although these were improved on previous risk management systems, the assessments in place continued to lack robust detail about the risks posed to people and how these should be managed.
● One person told us that staff did not always respond to incidents in a timely way to ensure their safety. The person told us about an incident where they had been assaulted by another person and explained, "The member of staff was useless, they should have stopped it before it got that far". Staff we spoke with also felt unprepared to handle incidents. One member of staff told us, "We aren't trained in restraint so when someone is being disruptive, there is nothing we can do. We are trained in low arousal but that does not reflect the people we have here and does nothing for them". This meant that staff were not trained or skilled in ensuring people's safety where incidents occurred that left people at risk of harm.
● The provider had no systems in place to learn lessons where things went wrong. Although staff had recorded accidents and incidents as they occurred, there were no systems to review these and plan how to mitigate the risks in future. In some instances, the interim management team were not aware of incidents that had occurred. In addition, the provider's electronic daily records gave staff opportunity to flag any areas of concern that they had about people. This was not being used effectively by the management team to review incidents. On the third day of inspection, we saw there were over 300 alerts on the system. There was no evidence these had been reviewed and when asked, the management team confirmed these had not been reviewed. This had meant that incidents that left people at risk of harm could not be acted on to reduce risk to people in future as these were not being monitored by the provider.

Poor risk management systems meant that risks to people could not be consistently managed and left people at risk of harm. This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Staffing and recruitment
● People gave mixed feedback when asked if there were enough staff to meet their needs. One person told us, "Yes there is always enough staff here, there is less at night, but they still look after us". However, another person told us that they at times had to wait for support. The person said, "If they [staff] are busy, it might take an hour or so, but usually its straight away. It is at night when you have to wait really".
● On the first two days of inspection, staff told us that there were not enough staff to enable them to meet people's needs. One staff member told us, "With the residents we have, no there is not enough staff". We spoke with the interim manager who told us that the staffing levels had been set by the provider and that there were no systems in place to assess how many staff were needed. The interim manager told us, "[The staffing numbers] have always been set like this ever since I have been here".
● We raised concerns about the staffing levels, and on the third day of inspection we saw the provider had used a dependency tool to asses the number of staff needed to meet people's needs. As a result of this assessment, the number of staff had increased. People and staff spoke positively about the increase of staff and one staff member told us, "Recently [the last few days] staffing levels have been much better, it's calmer, we are not rushing and have time to sit and talk with people".
● Although the staffing levels had increased and this had received positive responses, further work was required to ensure that regular reviews of people's needs were completed to determine the number of staff needed to keep people safe.

Using medicines safely
● Medication Administration Records (MARs) viewed, indicated that medication had been given to people as prescribed. MARs were completed accurately and signed for by the nurse administering medications. However, not all records contained detailed information and guidance to manage people's health conditions. For example, where people required medication that could cause other ill health or infection, there was no guidance for staff on what symptoms they should be looking for in relation to this. In addition,

where a person required medication to help with the management of their diabetes, there were no records informing staff of what a healthy blood monitoring score for this person would look like. The lack of guidance meant that temporary staff administering medication may not be able to spot signs of ill health in relation to the person's diabetes as they did not have the information about what is healthy for the person.

Preventing and controlling infection

● The home was kept clean and odourless. There were staff employed to ensure the cleanliness of the home. Staff had access to personal protective equipment where required to help prevent the spread of infection.

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 Good. At this inspection this key question has now deteriorated to Requires Improvement. 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 authorizations to deprive a person of their liberty had the appropriate legal authority and were being met.

- We found that where people lacked capacity to make certain decisions, there were no mental capacity assessments completed. In addition, there was also no evidence of best interest meetings taking place to ensure that any restrictions were in the person's best interests. We raised this with the interim manager who had no knowledge of the Mental Capacity Act code of practice and was not aware that the assessments were their responsibility, where they had concerns about people's capacity.
- The provider had placed blanket restrictions on people's movements without considering individual's capacity. Some people were unable to access specific areas of the home without staff presence. Their access to these areas were restricted by locked doors. The interim manager could not provide an explanation and records did not clearly record why people were being restricted in these areas.
- One person was unable to leave the home without staff support and staff told us they had a history of attempting to leave. The person's care records indicated that the person required a DoLS authorisation as they were not free to leave. However, this authorisation had not been applied for. This meant that the person had been unlawfully deprived of their liberty as the provider had not acted in accordance with the Mental Capacity Act. On the third day of inspection, the interim manager had applied for a DoLS authorisation for this person.

The provider had not acted in line with the Mental Capacity Act where people lacked decisions to make certain decisions. This is a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

● Assessments of people's needs had been completed prior to them moving into the home. However, these assessments had not identified the level of support people required. Assessments did not fully consider people's life history, risks to their safety or their current care needs. As a result of the poor assessment process, the provider had potentially moved people into the home whose needs they could not meet. This was confirmed to us by a member of staff and the nominated individual. The member of staff told us, "It is heads on beds. We have such a mix of people here and they didn't consider that when taking people in. They used to take a nurse along to assess people so that they could have input on whether we could meet people's needs but higher management make that decision now". Another staff member added, "I don't feel I know enough about people before they arrive".

● The provider's assessment processes to ensure people's needs could be met, had not been undertaken in sufficient detail, before people began receiving care. Following the first two days of inspection, the provider employed a care consultant to support them make improvements at the service. On the third day of inspection, the consultant told us, "The other issue is that our assessments did not get a full picture of people's needs before we took them in. We have now identified people who were not suitably placed and have served notice [to have them moved to another home]".

● The nominated individual shared their new assessment tool with us that would improve the quality of the information gathered during assessments to enable the provider to made safer admission decisions. However, the provider had not yet had opportunity to test out their new assessment process.

Staff support: induction, training, skills and experience

● Staff did not receive training and support that provided them with the skills and experience required to support people effectively. One member of staff told us, "The trainings not the best". Staff felt ill equipped to support people with their complex mental health needs. One member of staff told us, "They [the provider] sold this as a rehabilitation unit but then placed people who are not suitable for rehabilitation. They [people] are too complex and the training doesn't match the people we have here". Another staff member told us they had not received training to support a person with their diabetes and said, "I have not done diabetes training, if having a hyper or hypo, I wouldn't know". 'Hyper' and 'hypo' refer to symptoms of ill health people may experience associated to their diabetes. We spoke with the nominated individual about the training provided to staff and they agreed that training provided had not previously been sufficient. They told us, "The training is yet to be sorted, when I say we need to do face to face training, all I get is cost, cost, cost".

● Following the first two days of inspection, the provider submitted an action plan that detailed their intention to deliver workshops to staff in areas including, risk management, care planning and safeguarding to address the areas of concern identified at this inspection.

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

● Although people spoke positively about the food available and had choice around when they would eat, the menu did not consistently promote a healthy, balanced diet. For example, there was only one meal choice listed on menus and a high number of these were dishes that did not promote healthy eating such as burgers, pizza and barbecue or fried chicken. We raised this with the interim manager who advised that all food was freshly prepared and was devised by the people living at the home. However, there had been no consideration about whether the final meal options, provided people with a balanced diet or healthier options should people not want what was listed.

●Where people were at risk to due weight gain, staff had not always acted on in a timely way. Records we looked at indicated that one person had gained a significant amount of weight over a period of 12 months. We queried this weight gain with the nurse who informed us that the person had put on weight but disputed

the amount of weight gain recorded. We asked what action had been taken to support the person with their weight gain and was told that a referral had recently been made to health professionals. However, this referral was not made until the person had reached a potentially unhealthy weight. This meant that weight monitoring procedures had not been effective in identifying and acting on weight concerns in a timely way.

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

● The building was new, and purpose built with adequate indoor space for people to spend their time, including two communal lounges and a dining area. For those who wished to spend time outdoors, there was a spacious garden and outdoor gym area.

● The management team had previously sourced an external professional to assess the risks in relation to the building. This report recorded that although no remedial action was required, the provider should consider taking other measures to ensure the safety of the environment. These actions had not been taken. It was clear that management at the service had opposing views on whether changes were needed to the environment to address risks to people's safety. Whilst the nominated individual felt that some additional changes were required to fixtures and fittings to ensure that the premises would be safer for people, this was disputed by the provider and care consultant who had assessed the environment and felt no further work was required. As the management team could not agree on the actions required, the provider sought the advice of a second external health professional to help them assess the environment. The external health professional made a series of recommendations that would support the provider to ensure the safety of the environment. We are awaiting further information about the actions the provider intends to take in relation to this.

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

● The provider had employed health professionals to support people living at the service. This had included an occupational therapist and psychotherapist. However, due to changes within the staff team, people had not had consistent access to these services. This was confirmed by the nominated individual who told us, "Their [people's] access to therapy has been sporadic". The nominated individual also told us, "When I arrived, no one had [therapy] input bar one person. This was due to refusals, but no-one encouraged this or asked again later. They [the provider] didn't even think about why people were refusing". The nominated individual explained that they had recently recruited a new Occupational Therapist and Psychotherapist and would begin putting plans together to support people more effectively.

● People told us that where they required healthcare input, for example from their GP, that this would be sought for them. Records showed that some people had received visits from other healthcare professionals including community mental health nurses.

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.

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 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

- People gave mixed feedback when asked about whether staff treated them well. One person said, "The staff are really nice to us. It's a comfort having them here". Another added, "The staff are friendly". However, one person did not feel that all staff were kind to them and added, "Well there are a couple of staff who blank you".
- Staff had developed friendly relationships with people and were seen chatting with people responding positively to this.
- Although staff were caring in their approach and spoke positively about the people they supported, the systems and processes implemented by the provider had not always supported staff to display their caring values. For example, the reduced staffing numbers seen on the first two days of inspection meant that staff were not always able to spend time with people to promote their well-being. This was confirmed by a staff member who told us, "Today it is quiet, people are out and about, but some days it has been difficult, people can be upset or angry and need to sit and talk, it all takes time and we have not always had that".

Supporting people to express their views and be involved in making decisions about their care

- People did not always feel involved in decisions about their care. One person could not have access to their cigarettes due to the risks posed if they were to use these independently. Although this action was taken to ensure the person's safety, the person told us this made them feel that they were not a partner in planning their care. The person told us, "It's like they [staff] have an authority over you here. Having to ask and say please for a cigarette which my own money bought, that I don't like. I am not a child and won't be treated like one". We could not see from the person's records, that they had been involved in these decisions.
- Meetings took place with people living at the home which gave them opportunity to speak with staff about activities they would like to take part in that day. We observed this meeting on the first day of inspection and saw that this was well attended.

Respecting and promoting people's privacy, dignity and independence

- People were not consistently treated with dignity. One person's care records informed staff that where the person was being aggressive towards staff, that they should remove the person's games console until the person began to engage with staff. This was further evidenced in an incident log where the person had items removed from their room following an incident where they had attempted to injure staff. The removal of meaningful items from the person in response to difficult behaviour, did not promote dignity for this person.
- We saw staff promoting people's independence. Staff supported one person to improve their daily living

skills by practising their baking skills in the kitchen. Other people were being supported to become more independent in the community and go out without staff support.

Requires Improvement

Is the service responsive?

Our findings

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

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 people's needs were not always met.

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

● Permanent staff working at the service knew people well. Staff spoken with displayed a good understanding of people's needs and preferences with regards to their care. However, this knowledge had not been reflected within people's care records. Care records did not fully explore people's preferences or goals and aspirations. The service model for Oak House indicated that people would receive rehabilitation to support them into further independent living. However, there was no evidence in records that people had been asked about their future goals so that these could form part of the person's care. Where staff had begun looking at people's capabilities and how these could be improved in line with the rehabilitation model, this had been inconsistent. For example, although people had been assessed for going out of the home independently, we could not see any evidence of follow ups to the assessment, or care plans detailing the actions required to upskill the person to be able to go out independently in future.

● We spoke with the occupational therapist employed by the provider who acknowledged that previously the support towards achieving goals had been inconsistent but that they now had a full staff team and had started to complete assessments and care plans to support people in achieving their goals.

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

● People told us that they had access to activities that met their interests. One person told us, "I like board games and I like arts and crafts". This person went on to explain that they would be supported to visit the local church and see their family at home. We saw other people being supported to visit the local shops and one person went to their own home for the day.

● Due to the number of staff available for people on the first two days of inspection, people sometimes had to wait for support to go out. This was confirmed by staff who gave examples of days where the number of people who needed to go out meant that there were not enough staff left within the home for others. The staff member explained that to manage this, they would have to try and rotate the time and frequency of people accessing the community so that there continued to be staff within the home. This had the potential to impact on people's care as there was not always enough staff to support them to access social activities outside of the home.

● Following the increase in staffing levels on day three and four of the inspection, staff reported that their availability had improved and that people had been able to go out more flexibly.

Improving care quality in response to complaints or concerns

● People knew who they could go to if they wished to complain or share a concern. Incident records we looked at showed that people had raised concerns with staff where they had these. However, people were

not always satisfied with the response to these concerns. For example, one person told us of an incident where another person had urinated on their windowsill. This had upset the person and they told us, "All they [staff] did was close the curtains. I never get any feedback from these incidents. It is hard living here".

● The interim manager was unable to locate any complaint records for the service and told us that no complaints had been received. As there were no records of any complaints, we were unable to review how complaints were managed.

End of life care and support

● No-one at the service required end of life care. Care records showed that people had not been asked about their wishes at the end of their life. This meant that should the person become unwell or pass suddenly, the provider would not have any information about the person's wishes to ensure these would be respected.

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 good. At this inspection this key question has now deteriorated 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.

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

● The provider had not ensured a positive culture within the service that achieved good outcomes for people. The ineffective initial assessment process meant that people's full needs were not always known prior to them moving into the home and resulted in staff being unable to meet people's care needs or support them into further independent living, which is the purpose of the service. This was acknowledged by the care consultant employed by the provider who told us, "We have just been a mental health unit, with one nurse keeping on top of everything, not particularly well led" and "Our staff have essentially been providing a very good babysitting service, that's not what [Oak House] was supposed to be." Both staff and the management team acknowledged that a restructure of the service was needed, and that work was required on ensuring that they meet their own service aims. One member of staff told us, "Change is needed".

● Staff told us they felt unsupported by the provider and it was clear that staff morale was low. Comments from staff members included, "I don't get any support, there is no-one here to support me" and "Since [the last manager] left, I have had no support, nobody [from the provider] really comes". Staff told us they were given tasks in addition to their job role and this had impacted on the care they were able to provide to people. One member of staff told us, "They [the provider] cut staff. They got rid of our admin and receptionist roles and now all of those jobs have been passed to me". The nominated individual agreed with this. Staff informed us that they had raised concerns with the provider, but no action was taken in response to their concerns.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics / Continuous learning and improving care

● People had been involved in regular meetings with staff in which they could discuss the service and what activities they would like. These were well attended, and we observed staff listen to people's feedback. However, the lack of monitoring of incidents, meant that where people shared feedback that indicated they could be at risk of harm, no action was being taken. People had also not felt involved when it came to making decisions around their care and people who had items taken away from them for their safety or who were not able to leave without staff support, did not always fully understand why these decisions had been made. This indicated that people were not involved in discussions around these decisions.

● The provider had not acted on feedback given to learn and improve the quality of care provided. Staff informed us that they had shared feedback with the provider about their concerns about the service. These concerns related to an ineffective call system, where staff reported that they were unable to view where an

alarm was sounding without visiting the office first, staffing levels and workload. However, staff felt that their feedback had not been listened to. One member of staff told us, "We have told them [the provider] and nothing happens". We raised this with the nominated individual on the third day of inspection and she told us, "I told [the provider] all of this and he just looks at me and blames the managers".

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

● Although audits of the service had been completed in areas such as health and safety, infection control and catering, there was no oversight of the care provision. We were unable to see that care files, incidents or safeguarding's were reviewed. This had led to serious allegations of abuse not being acted upon, and key information about how to keep people safe being left out of care records. The interim manager told us that the provider did have a tracker tool to monitor incidents and safeguarding, but these had not been implemented at this service.

● The provider lacked oversight of the service and was unaware of the concerns we found at this inspection. The care consultant employed by the provider told us, "[The provider] needs informing about what's going on and the clinical side but that hasn't happened". We were unable to see any evidence that the provider facilitated meetings with their managers or staff within the service to gain an understanding of the quality of care being provided.

● The provider did not understand the regulatory requirements of their role. There had not been a registered manager in post since 2017. Although a manager had been in post until April 2019, no application to register had been made. It is a condition of the provider's registration that they have a manager registered with CQC. The provider was unaware that their manager had not registered as a manager for the service and therefore were not meeting the condition of their registration.

The lack of oversight of the service had left people at risk of harm. This is 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 / Working in partnership with others

● The provider had not acted on their duty of candour. There was a closed culture within the service that meant that that incidents and concerns were not shared or investigated. While staff had recorded incidents and left these for the attention of management, these had not been followed up or shared with the local authority and CQC. The lack of action in response to incidents and concerns left people at risk of harm. Although the provider undertook a review of all incidents following the inspection, they had not implemented systems prior to this to ensure that where something goes wrong, they were open and transparent about these.

● It is a legal requirement that the provider shares with us information about incidents that have occurred at the service. The provider had not shared this information with us as required.

The failure to inform CQC of incidents that occurred that the service is a breach of Regulation 18 Care Quality Commission (Registration) Regulations 2009.