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Oak House Care Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

Oak House Care Home is a grade two listed building situated in the town of Axminster. The service is registered to provide care and accommodation for up to 17 people. They provide care and support for frail older people and people living with dementia. There were 15 people living at the service when we visited, with one person in hospital.

People's experience of using this service and what we found
People were not safe at Oak House. There was not an effective system to identify and manage risks associated with people's care. People's individual risk assessments for their health and safety had not been regularly reviewed to ensure they reflected people's current level of risk.

People were at risk of poor nutrition and hydration as there was poor oversight of people's fluid and diet intake. People were not being weighed regularly and there was no clear oversight about whether people had lost weight and whether appropriate referrals were needed.

Fire management at the home was unsafe. External contractors undertook regular servicing and testing of moving and handling equipment, fire equipment and lift maintenance.

The Environmental Health Technical officer had undertaken an inspection on 27 September 2021. They had identified major improvements were required at Oak House and gave the service a one-star rating. One of the areas they identified was that records were not completed. At the inspection we found continued gaps in kitchen and cleaning records. This indicated that lessons had not been learnt to ensure improvements were implemented. The registered manager told us they would restart the kitchen monitoring records and ensure they were completed.

Staffing levels were not always adequate to ensure people's needs were met in a timely way or to keep people safe. People were sat in the communal areas for long periods of time with no staff present. People did not always receive person centred care due to the poor staffing levels. They were receiving task orientated care. Staff said they felt they were frequently short staffed on shifts. They explained this meant some people did not have their regular showers or baths.

People were not protected from potential abuse and avoidable harm because systems and processes in place were not always effective. The management team had not appropriately raised safeguarding issues with the correct authorities, notified Care Quality Commission (CQC) or completed thorough investigations.

The provider did not have a system to ensure relevant checks were made to ensure staff were of good character and suitable for their role prior to employment.

There were poor infection prevention and control measures in place at Oak House. Staff did not always use PPE effectively and safely and in accordance with current government guidelines. Although there was a

cleaning regime in place, we found some areas of the premises were not clean.

Not all staff had received the required training to support people safely. New staff had not received a comprehensive induction when they started working at the home. People's needs were not reassessed when they returned from hospital to ensure staff had the required skills and equipment to support them.

Staff had not been supported through regular supervisions and staff meetings. They had not had the opportunity to discuss their work, receive feedback, and identify further training and development needs.

People were positive about the food they received. Improvements were made during the inspection to put in place menus to advise people of the meal choices. We were not confident people who chose to eat in their rooms were being offered a choice and whether staff were offering them an alternative if they didn't like the meal brought to them. We raised this with the management team, who assured us people always had a meal choice.

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 in practice although; the policies and systems in the service supported this practice.

Medicines were safely managed. The provider used a computerized medicine system which was linked to the providing pharmacy. Staff administered medicines using a handheld device which would alert staff if a medicine had been missed.

The providers quality monitoring systems did not identify concerns and ensure the safe running of the service. Most audits had not been completed and therefore had not identified risks and areas of concern found at the inspection.

The provider did not have an environmental plan. We found some areas of the home in a tired state of repair. We were told some carpets had been replaced and vacant bedrooms decorated and that they had plans to decorate the communal areas. They told us in their service improvement plan dated 28 October 2021 they would complete an audit of all rooms to prioritise works needed.

The providers and management team acknowledged to us they knew there were concerns at the home and said that everything we told them they already were aware of. After the first day of the inspection the management team completed a service improvement plan setting out how they were going to address the concerns we had identified.

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 17 February 2018).

Why we inspected
We received concerns in relation to staffing levels, staff training, people's safety, cleanliness of the service and the management style and culture. Following information of concern about food safety being shared with CQC, The Environmental Health Technical officer had undertaken an inspection on 27 September 2021. They identified that major improvements were required and gave the service a one-star rating. As a result, we undertook a focused inspection to review the key questions of safe, effective and well-led only.

We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. 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 Inadequate. This is based on the findings at this inspection.

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

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

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

We have identified breaches in relation to safeguarding, risk management, person centred care, staffing levels, training and competency, recruitment and good governance.

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

Follow up
We will meet with the provider and 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.

Special Measures:
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.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Oak House Care Home on our 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?

Inadequate

The service was not effective.

Details are in our effective findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-Led findings below.

Oak House Care Home

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.

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

Inspection team
The inspection was carried out by two inspectors

Service and service type
Oak House Care Home 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 had a manager registered with the Care Quality Commission. The registered manager was one of the providers of the service. A registered manager and the provider are legally responsible for how the service is run and for the quality and safety of the care provided. There had been two registered managers at the service until one deregistered with CQC on 30 September 2021.

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, this included notifications made by the service and concerns raised with the Care Quality Commission. We used all of this information to plan our inspection.

We sought feedback from the local authority and professionals who work with the service, including the safeguarding team and community nurses. 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 of this information to plan our inspection.

During the inspection
We met most of the people who lived at the home and spoke with four of them about their experience of the care provided. We also spoke with a relative visiting the home to ask them about their view of the service. We also spoke with two relatives on the telephone

We spoke with ten members of staff including the registered manager who is also one of the provider's, the provider's area manager, the acting manager, the deputy manager, the maintenance person, care workers and the housekeeper. We also spoke with two of the providers. We also spoke with two healthcare professionals visiting the service to ask about their views.

As most people were living with dementia, we used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We observed people and staff in the two lounges and dining areas during breakfast, morning, lunch and afternoon.

We reviewed a range of records. This included six people's care records and 12 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 policies and procedures, maintenance records, cleaning schedules, staff rota's, monitoring charts, fire documents and external servicing records were reviewed.

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

Inadequate

Is the service safe?

Our findings

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

At the last inspection this key question was rated as 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.

Assessing risk, safety monitoring and management

●There were mixed responses from people and relatives when they were asked if they felt safe. People commented, "Yes…don't see the staff much…They just bring my meals. Never have time to chat or be sociable…They are very nice to me when I do see them". A relative told us "Yes (relative) is safe here. They use risk judgement, no concerns about safety".

●People's individual risk assessments for their health and safety, which included the risk of falls, nutrition, bedrails, choking and skin care had not been regularly reviewed to ensure they reflected people's current level of risk. This meant that action might not have been taken to mitigate the risks to people.

●There was not an effective system to ensure pressure relieving mattresses were set at the correct setting for the individual using them. We found one person who had their pressure relieving mattress set for 80 to120kgs, the person weighed 51.2 kgs. This meant the mattress might not be effective at relieving pressure for the person and placed them at risk of developing pressure areas.

●Risk assessments had not been completed for a person who had been at the home since June 2021, except for a fluid risk assessment. The person had complex healthcare needs and was at a significant risk of developing complications if the right actions were not put in place. The management team had not identified risk assessments had not been completed.

●People were at risk of choking because staff were not being guided about the required consistency of diet they required. One person was given steak and kidney pie when the speech and language team (SALT) had advised they had main meals at 'level 5 format (minced and moist)'.

●Fire management at the home was unsafe. Fire records were incomplete and did not demonstrate, fire tests were being carried out regularly, fire doors were closing, and fire exit routes checked. Therefore, we could not be assured checks were regularly taking place and the management team had an oversight of the fire monitoring system.

● The provider's policy stated a fire risk assessment should be completed annually. Although comprehensive, the fire risk assessment had been completed in June 2019 and had not been reviewed and updated.

●The laundry room was full of clutter which included combustible items such as cushions and pillows, up against the tumble dryer causing a possible fire hazard. This had not been identified by the management team. Staff were required to check and clear the tumble dryer filter twice a day. Records showed there were numerous gaps, so the tumble dryer was not being regularly checked. We made the provider aware of these concerns and they took action and we saw on the second day of the inspection the laundry had been tidied and cleared.

● People's personal emergency evacuation procedures (PEEPs) were recorded on a quick access reference sheet in the main entrance. This detailed the support individuals needed in the event of an emergency to keep them safe. This was not up to date and did not reflect who was in the home and that people had

changed bedrooms. Rooms at the home were not numbered but named after trees. Some of these names had fallen off which meant it was not clear who was in which room. This meant that in the event of an emergency the emergency services would not have a clear plan of who was in the home and where they were. The provider took action and on the second day bedrooms were all numbered and the quick reference sheet had been updated to reflect who was in the home

●People were at risk of poor weight management as there was poor oversight of people's weights. People's weights were sometimes being recorded on the providers computerised system and at other times on pieces of paper. It was not clear if people had been weighed and whether they had lost weight. One person required weekly weights but had not been weighed weekly and their care plan had not been reviewed to assess if further action was needed. Therefore, people's weight monitoring was not effective.

Preventing and controlling infection

●We were not assured that the provider was using personal protective equipment (PPE) effectively and safely. Staff did not always use PPE in accordance with current government guidelines. This meant people were placed at risk of infection because PPE was not always worn appropriately. During the inspection we saw staff remove their face mask at times when in communal areas and in contact with other staff. At times we saw staff wear their masks below their nose or around their chins or necks. We reminded staff on a number of occasions about wearing their masks correctly. Although other staff were in the area no staff challenged these practices.

●We were not assured that the provider was meeting shielding and social distancing rules. No-one at the service was shielding, and communal areas were set up to promote social distancing. Because of low staffing levels, there was little staff presence, supervision and support in communal sitting rooms. One or two people did not appreciate social distancing and the lack of staff presence meant one person intruded on other's personal space. We saw minor altercations between two people, but staff were not at hand to intervene effectively.

● We were not always assured that the provider was preventing visitors from catching and spreading infections. Although the inspection team was asked to show evidence of their negative Covid-19 tests results, the inspection team was not asked to have their temperatures recorded in line with the provider's policy.

●We were not always assured that the provider was admitting people safely to the service. Although people admitted to the service were tested for COVID 19, infection control precautions were not put in place. One person had been recently discharged from hospital. We observed staff did not always wear the correct PPE when attending to them. We shared the concern with the management team who took action to address the concerns. This included ensuring a clinical waste bin was provided and that PPE and hand gel were placed outside the room so staff could readily access the equipment they needed.

●We were not always assured that the provider was promoting safety through the layout and hygiene practices of the premises. Some areas of the premises were not clean on the first day of inspection; a soiled pad on the floor, commodes not emptied and faeces on the floor in one bedroom. Not all areas of the service or equipment was clean. The ground floor shower and toilet were dirty, and a raised toilet seat was soiled and stained.

●The laundry room was small and disorganised. We saw it was difficult to separate clean and dirty laundry. The laundry was cluttered with hangers; pillow and cushions, which presented a potential hazard. The washing machines had an automatic system to add detergent to the wash cycle. We found the detergent had run out and laundry was being washed without detergent. This was addressed by the second day of the inspection. The laundry had been cleaned and decluttered and new bottles of detergent and softener had been put into place.

●Cleaning schedules were in place but there were gaps where the cleaning staff were not on duty. We couldn't be confident daily cleaning was happening. There was no indication that frequently touched points

were cleaned regularly as there was no recorded evidence of this. Cleaning staff confirmed this was done twice a day by them and then by night staff. Not all bedrooms and communal bathrooms had pedal bins, this was addressed on the second day after being brought to the provider's attention.
●We were not assured that the provider was making sure infection outbreaks could be effectively prevented or managed.

Learning lessons when things go wrong
● The provider had not ensured lessons were learnt and actions taken to address issues. Staff had recorded accidents and incidents, but it was not clear any action had been taken to reduce the risks to people or referrals to external professionals made. For example, two incidents where people had caused harm to others.
●The Environmental Health Technical officer had undertaken an inspection on 27 September 2021. They identified that major improvements were required and gave the service a one-star rating. One of the areas they identified was that records were not completed. We identified continued gaps in kitchen and cleaning records. This indicated that lessons had not been learnt to make sure improvements were implemented. The registered manager told us they would restart the kitchen monitoring records and ensure they were completed.

People's risks were not well managed to keep them safe. This is a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

●After the first day of the inspection the management team completed a service improvement plan setting out how they were going to address the concerns we had identified.
●External contractors undertook regular servicing and testing of moving and handling equipment, fire equipment and lift maintenance.
● We were assured that the provider was accessing COVID -19 testing for people using the service and staff.
● We were assured the provider was facilitating visits for people living in the home in accordance with the current guidance.
● We were assured that the provider's infection prevention and control policy was up to date.

Staffing and recruitment
● Staffing levels were not always adequate to ensure people's needs were met in a timely way or to keep people safe. We observed people sat in the communal areas for long periods of time with no staff present. When staff did go into the communal areas it was to undertake support tasks. We observed people not recognising others personal space, which resulted in verbal altercations between some. There were no staff in the area to defuse or distract these engagements.
●We received mixed feedback from people using the service about staffing levels. While people confirmed staff were kind and caring, they explained they could wait for attention. Comments included, "I don't see staff very much, apart from mealtimes. They never have time to chat or be sociable. How long you wait for them when you ring depends. It can be quite a while" and "The staff are lovely but not enough of them…" A relative told us, "I see the same staff, so there is continuity but a high turnover".
● The provider had not carried out a need's analysis and risk assessment as the basis for determining sufficient staffing levels. Staff told us there were seven people who required two staff to support them at times and five people who required support with their meals. The registered manager told us that their preferred staff level at the home was a senior care assistant and three care staff during the day with a member of the management team. Rotas showed at times there was only a senior care assistant who undertook medicine administration and two staff available. This meant other people were left at risk when staff were supporting one of the seven people.

● Staff said they felt they were frequently short staffed on shifts. They explained this meant some people did not have their regular showers or baths. Staff also reported they were at times unable to take breaks. Staff comments included, "Some days it could be just two staff on… would like more staff"; "Hard work and non-stop" and "More staff would be amazing…that is my major concern…can work 12 hours without a break as must have two staff on the floor; showers get missed and baths…time is rushed." One person told us they had not had a bath or shower since being at the home. This was confirmed by feedback from the community nurse team who supported the service. They told us, "Poor hygiene for some residents".
● The provider had staff vacancies they were trying to recruit for. Staff undertook additional shifts to help where they could but were working very long hours. The provider did not use agency staff to fill in where they were short staffed. The management team were working alongside staff to help where they could. A staff member told us, "There are not enough staff here…they need to use agency but won't."
● People were seen sat in the communal areas with a television on and nothing to engage or stimulate them. One person said, "Nothing to do, just sit and stare down there (communal area). Used to have more going on". When asked what they would improve they told us, "Staff could check me and look in on me more often… More activities would be good." There was not an activities coordinator at the time of inspection. The provider told us they had recruited an activity person and were awaiting employment checks. This was confirmed by feedback from the community nurse team who supported the service. They told us, "Lack of stimulation for residents, the use of appropriate music for age group."

Due to lack of sufficient staffing levels, people's needs were not met, and people were placed at risk of harm. This is a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider did not have a system to ensure relevant checks were made to make sure staff were of good character and suitable for their role prior to employment. They had not ensured new staff had a relevant disclosure and barring service check (DBS) to confirm whether the applicants had a criminal record and were barred from working with vulnerable people. As part of their recruitment process they had not explored new staff's employment history.

The provider had failed to ensure recruitment procedures were operated effectively. This was a breach of regulation 19 (Fit and proper persons employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The providers had identified they had been having difficulties retaining staff. On the second day of the inspection they had undertaken a supervision with one staff member and asked them to be the staff wellbeing lead. They told us they would source training to help them undertake their new role.

Systems and processes to safeguard people from the risk of abuse
●People were not protected from potential abuse and avoidable harm because systems and processes in place were not always effective.
● The management team had not appropriately raised safeguarding issues with the correct authorities, notified Care Quality Commission (CQC) or completed thorough investigations. We read incident reports in the home for October 2021. We found two incidents that should have been reported as safeguarding concerns to the local authority and CQC. Staff did not recognise the incidents as possible safeguarding issues.
●Not all staff had completed safeguarding training. Out of the 16 staff only seven had completed safeguarding training. The provider had identified this before our inspection and had enrolled the remaining staff on a training course. One staff member told us they had not had "Proper" safeguarding training, but the

previous registered manager had, "walked me through it".
●Staff told us they would report any concerns to the management team and would expect action to be taken. Talking to the management team it was not clear that the management team would follow safeguarding procedures as they said in the past, they had encountered difficult experiences.
●Staff were unsure which external organisations could be contacted if they felt concerns were not being acted on by the management team.

Due to poor safeguarding systems, processes and practices at the service, people were placed at risk of harm. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

Using medicines safely
●Medicines were safely managed. The provider used a computerized medicine system which was linked to the providing pharmacy. Staff administered medicines using a handheld device which would alert staff if a medicine had been missed.
● Medicines were stored safely. There were suitable arrangements for ordering, receiving and disposal of medicines, including medicines requiring extra security. Each month excess medicines were returned to the pharmacy.
●Staff administering medicines had received training in the use of the medicine computerized system. The staff training matrix showed only two senior staff had completed the advanced medicine training and it was not clear if staff had their competency regularly reviewed.
● Staff were observed taking time supporting people with their medicines. They ensured the person had a drink and stayed until the medicines had been taken.
● Where people were prescribed 'as required' medicines, individual protocols were in place to guide staff in their use.
●Regular medicine audits had not been completed. However, during the inspection, a medicine audit had been completed and no errors or concerns were identified.
● Fridge temperatures were monitored to check medicines were stored at recommended temperatures. We discussed with the area manager that staff were not resetting the fridge temperature after each reading. This meant that the minimum and maximum fridge temperatures being recorded remained the same. The area manager said they would put up a sign to remind staff to press the reset button after each reading.

Inadequate

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 Inadequate. This meant there were widespread and significant shortfalls in people's care, support and outcomes.

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

●People's needs were assessed prior to moving into the service. Consideration was not always given as to whether staff had the skills and knowledge to be able to meet people's needs before they moved in. For example, one person returned to the home following a stay in hospital and staff had not ensured they had infection control practices in place due to the pandemic. They did not have pressure relieving equipment in place and staff did not have the pain management skills to support the person.

●Staff completed a pre-admission document on the provider computerised care system for new people. This was used for most people to write care plans to advise staff about people's needs. However, when a person returned from hospital staff had not discussed with the hospital their new needs. They had not completed a re-admission assessment, reviewed their risk assessments and updated their care plans to reflect their changing needs. This meant appropriate measures were not put in to place to ensure their safety. For example, regular repositioning, appropriate monitoring of diet and fluids and oral care.

● Another person had been admitted to the home in June 2021 with complex health needs. Staff had only completed a fluid risk assessment for this person. No assessments had been carried out for their skin integrity, weight monitoring, falls risk assessments, choking and bedrails assessment. This meant this person was at risk of not having appropriate measures put into place to ensure they were supported safely.

● Care plans for some people were very detailed and reflected people's needs and preferences. These had not been regularly reviewed or updated with people's changing needs. The provider's computerised system generated a monthly report which showed in September 2021, 75 care plans and risk assessments had not been reviewed. This meant staff might not be providing people with appropriate care.

●People were not receiving the support they required. The provider had a computerised care plan system. The system alerted staff when actions were needed, for example, repositioning, diet and fluids. Staff used a handheld electronic device to record support tasks they had carried out. We found these were inconsistently completed. On people's, main page on the computer system there were numerous red alerts which demonstrated tasks had been missed. Some people had paper monitoring charts which caused more confusion as some staff completed these and others on the computerised system.

●People were not receiving person centre care. They were receiving task orientated care. For example, people had to wait until most were dressed and ready to be taken to the dining room for breakfast. Another example was people were taken to the toilet prior to lunch and placed in their wheelchairs until everyone had been supported to use the toilet and then went down to the dining room. We observed one person who sat all morning in his wheelchair with the hoist sling still in place, without a pressure cushion, was taken down for lunch and was not taken out of his wheelchair until the afternoon. A staff member told us, "I feel we can't support people and things get missed…running from one job to another… task orientated at the

moment."

The provider had not ensured people had care or treatment that was personalised specifically for them. This was a breach of regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff support: induction, training, skills and experience

● Staff had not received the required training to support people safely. An audit of staff training had been completed by a staff member from one of the providers other homes on 11 October 2021. They had completed a training matrix to show training staff had completed and where there were gaps. They had enrolled staff on training courses where there were gaps, but these had not been completed at the time of the inspection. The training matrix showed for the provider's mandatory training, out of 16 staff, six had completed fire safety, seven had completed food safety, six had completed health and safety and seven safeguarding. Of the 13 staff only five had a qualification in health and social care and three had completed the care certificate (programme which had been introduced in April 2015 as national training in best practice). This meant that although the provider had identified staff training deficits, staff were deployed who did not have the skills to support people safely. This was confirmed by feedback from the community nurse team who support the service. They told us, "Not enough appropriately trained staff".

● Staff had not received a comprehensive induction when they started working at the home. Staff told us they worked alongside a more experienced care worker when they started work at the home, but they were not supernumerary and were counted in the numbers. The area manager told us; they were in the process of reviewing induction as they felt it needed to be more thorough. They said new staff were completing and doing shadow shifts depending on their experience and need.

●Staff demonstrated a poor knowledge of pain relief. On the training matrix only three staff had completed the medication advanced training. The area manager said staff had completed the training specific to the computerised medication system. No competency assessments had been completed to ensure staff were administrating medicines safely.

● Staff had not always received opportunities to discuss their work, receive feedback, and identify further training and development needs through supervision or staff meetings. We discussed this with the management team after the first day of the inspection. On the second day of inspection the providers had completed three staff supervisions. One of the providers told us, they would "Complete a supervision matrix" as they planned to do supervisions for all of the staff.

The provider had not ensured staff had the appropriate support, training, professional development and supervision to enable them to carry out their roles. This is a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

●On the second day of the inspection the registered manager and one of the provider's told us they had undertaken a supervision with three staff and planned to undertake supervisions with all of the staff.

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

● Systems were not in place to ensure people received their required nutrition and hydration. Staff were recording people's diet and fluid intake in two different places. Some recorded the information on the providers computerised care system and others recorded on paper charts. This meant it was not clear that people were receiving their required dietary and fluid intake.

●The provider said staff were enrolled to undertake training on the computerised care system to know how to add information on the handheld devices which connected them to the system.

●On the first day of the inspection people were not always aware of the meal choices. One person told us,

"It's always a surprise". We discussed this with the registered manager. On the second day of the inspection there were menu's in the dining room to advise people of the meal choices.
●We were not confident people who chose to eat in their rooms were being offered a choice and whether staff were offering them an alternative if they didn't like the meal brought to them. For example, one person in their room had a cold meal on the table in front of them, which they said, "Not fancying that today". We highlighted to a staff member they didn't want that meal and an alternative meal was brought up which was cold. After we highlighted this to the staff member, they warmed the meal up and the person said they were enjoying the meal. We were not sure if we had not highlighted this concern if the person would have been offered an alternative.
● People were positive about the food they received. Comments included, "Lunch today was lovely. I've had plenty to eat today" and "I eat what I want…no bother about food". When asked if they got offered a choice one person said, "sometimes".

Adapting service, design, decoration to meet people's needs
●The provider had undertaken some improvements to the home. This included new carpets and redecoration of vacant rooms and painting of hallways. We saw that the main communal areas and some bedrooms had chipped paintwork and looked tired. The provider said they were intending to redecorate the lounges but did not have an environmental plan. The provider told us in an action plan they sent us after the inspection, that the maintenance team would undertake an audit of the home to identify areas which required attention. One of the provider's told us they had been experiencing difficulties with the passenger lift and a significant overhaul was scheduled to be undertaken at beginning of 2022.

Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care
●People had had access to health care professionals. During our visit a community nurse practitioner came to the home to undertake a dressing. They told us, "They (staff at Oak House) alert us in a timely way, regarding any wounds or pressure sores; they phone, and we visit".
●People and relatives told us they or their family members received medical input when they needed it. A relative told us they were told when their relative was unwell and that staff had called in the GP. Records confirmed that staff contacted health care professionals if they had any concerns.

Ensuring consent to care and treatment in line with law and guidance
The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA.

In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

● Where people lacked capacity, mental capacity assessments were undertaken. People's legal representatives, relatives and professionals were consulted and involved in best interest decisions. A relative told us that staff always considered their relatives best interest and consulted them.

●The area manager understood the MCA and the principles of making any decisions in people's best interests. They had worked with the management team to complete the required documentation and consult with the relevant authorities.

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.

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

●The providers quality monitoring systems did not identify concerns and ensure the safe running of the service. The majority of audits had not been completed and therefore had not identified risks and areas of concern found at the inspection.

●The provider had not ensured people were receiving the support they required. The provider had a computerised care plan system which recorded support tasks carried out by staff and alerted when tasks had not been completed. The provider had not followed up where numerous tasks were not completed for most people.

●The provider had a poor oversight of people's weights. People's weights were not always being recorded on the providers computerised system but being recorded on pieces of paper. It was not clear if people had been weighed and whether they had lost weight. Therefore, people's weight monitoring was not effective.

●The provider had not ensured people's care needs and individual risks were regularly reviewed and monitored to keep them safe. People's care records were recorded on the providers computerised care plan system. We found the monthly reviews of people's individual risk assessments and care plans had not been completed. The providers computerised care system could produce a monthly report which identified care needs reviews and assessment reviews which were overdue. For example, in September 2021, 75 care needs, and risk assessments were overdue. This does not include the risk assessments of one person who came to the home in June 2021 who had not had risk assessments completed.

●The provider did not have a clear protocol in place to guide staff about readmitting people safely back into the home. This meant that safety measures were not put in to place for one person and had put them at risk of harm.

● The provider had not ensured there were enough staff to support people safely. They told us they had been having difficulty recruiting staff and had experienced difficulty retaining staff. They said quite a few staff had left without giving any notice. Staff rota's showed staff were working a lot of hours and we saw staff were very busy throughout our visits, working extremely hard. Staff said they had been short of staff on most shifts and were extremely tired. The registered manager told us on the second day they had undertaken a supervision with a senior care assistant, and they were going to take on the role of the wellbeing lead and they were looking for appropriate training to enrol them on.

●The provider had not ensured staff had received the required training to have the skills to support people safely. New staff were shadowing existing staff to learn the role but were not supernumerary and had not undertaken a formal induction. The provider had not ensured staff had received regular supervisions and staff meetings to identify further training and development needs, support required and gain feedback.

●The provider had not ensured there were always good infection control practices at the home. They had not led by example by wearing PPE correctly and ensured staff also wore their PPE as required by government guidance.
●Infection control audits had been carried out and had identified odours on the last three completed. Both providers said they were aware of the odour and had spoken with the night staff about undertaking carpet shampooing. There was nothing recorded to demonstrate this action had happened.
●The provider did not have a system in place to ensure people had the required dietary consistencies recommended by the speech and language therapists (SALT). One person's care record detailed their required dietary needs. This information had not been shared with the kitchen staff and we observed the person eating food which was not the consistency recommended by the speech and language therapist (SALT).
●The provider had not ensured there were good standards of food hygiene at the home. Oak House had been inspected by the Environmental Health Technical officer on 27 September 2021 who identified that major improvements were required and gave the service a one-star rating. They had identified staff did not have the required food hygiene training, records were not completed, food was not stored safely, kitchen audits were not completed, and areas of the kitchen were not clean and required redecoration. They had returned on 8 October 2021 and seen some improvements and were intending to return. We identified continued gaps in kitchen and cleaning records. The registered manager told us they would restart the kitchen monitoring records and ensure they were completed.
●The provider did not have an environmental plan. We found some areas of the home in a tired state of repair, radiator covers were not on two radiators, this had not been risk assessed and could expose people to the risk of burns from a hot surface. Both lounges were in a poor state of decoration and paintwork around the home was chipped. The registered manager said they had replaced some carpets and decorated vacant bedrooms and had plans to decorate the communal areas. They told us in their service improvement plan dated 28 October 2021 they would complete an audit of all rooms to prioritise works needed.
●The provider had not ensured fire safety procedures at the home was safe. Fire monitoring records were not complete; therefore, it was not clear if regular fire alarm tests were being carried out, checks of fire doors and exit route were being monitored. Clutter which was combustible in the laundry room was a possible fire hazard which had not been identified by the provider.
●The provider had a fixed wire test of the electricity at the home in June 2015 which was satisfactory with a recommendation it was retested in July 2020 (five years). This had not happened in 2020 due to the pandemic. We told the provider that this was 15 months overdue and should be completed. We requested that the provider inform us when it was going to be completed.
● The provider had not appropriately raised safeguarding issues with the local authority and submitted statutory notifications to the Care Quality Commission (CQC).

We found no evidence that people had been harmed. However, systems were either not in place or robust enough to demonstrate safety was effectively managed. This placed people at risk of harm. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider failed to notify the CQC of safeguarding incidents. This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

●By the second day of the inspection the provider had revised their service improvement plan, setting out how they were going to address the issues found.
●The area manager had identified the management team at Oak House required information about their roles and responsibilities. In particular what they were required to inform CQC about. On the second day of

the inspection they told us they had put in place a 'Crib sheet for senior staff…to prompt them".

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

● Families gave us mixed views about being consulted and involved in day to day care decisions. One relative said they were kept informed another said they were not always informed if their relative was unwell or had a fall.

●People and staff had not been asked for their views in satisfaction surveys. The provider had not undertaken any assurance surveys since November 2019 or held residents' meetings. An audit carried out on the 30 October 2021 had identified resident meetings were not taking place and recorded as an action on the audit that 'Residents meeting would be arranged when the new activities coordinator started'.

● Daily handovers were held by the staff member leading the shift, who ensured the care staff were made aware of any issues to follow up.

● Health professionals told us there was sometimes poor communication with them. We observed staff contact the community nurses to alert them about a concern.

●People and staff gave mixed feedback about how well-led the service was. One person told us, "This is the worst it has been…had a good reputation but not now".

● People did not always receive person centred care due to the poor staffing levels.

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; Continuous learning and improving care.

●The providers and management team acknowledged to us they knew there were concerns at the home and said that everything we told them they already were aware of. One provider told us, "We have identified a lot of things…the plan was there, it was the logistics which meant it had not been completed."

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 18 Registration Regulations 2009 Notifications of other incidents The provider failed to notify the CQC of safeguarding incidents. This was a breach of regulation 18 (Notification of other incidents) of the Care Quality Commission (Registration) Regulations 2009.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider had failed to protect people from abuse and improper treatment. This was a breach of Regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider did not have robust recruitment procedures in place to ensure staff employed were 'fit and proper'. This was a breach of Regulation 19 (Fit and proper persons employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulation.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider had failed to carry out thorough assessments of care needs or to reassess the impact of people returning to the home. This was a breach of Regulation 9 (Person-centred Care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

CQC issued a warning notice.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to adequately assess and monitor the risks relating to the health safety and welfare of people and had failed to mitigate the risk of infection transmission and had not implemented guidance to manage COVID-19. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

CQC Issued a warning notice.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider's systems and processes were not established and operated effectively. They had failed to consistently assess, monitor and mitigate risks to people's health, safety and welfare. This was a breach of regulation 17 (Good

Governance) of the Health & Social care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

CQC Issued a warning notice.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had not ensured there were sufficient numbers of suitably qualified, competent, skilled and experienced staff to meet people's care and treatment needs. The provider had failed to give staff appropriate support, training, supervision and appraisal as is necessary to enable them to carry out their duties. This was a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulation.

The enforcement action we took:

CQC Issued a warning notice.