Care Homes UK Ltd

Oak Lodge

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Oak Lodge is a residential care home providing accommodation with personal care to older people, some of whom were living with dementia. The service can support up to 28 people in one building over two floors. At the time of this inspection, 15 people lived at the service

People's experience of using this service and what we found
Risks which affected people's health, safety and wellbeing were not always documented. This meant that staff did not always have adequate information to manage and mitigate risks to people. Accidents and incidents had not been thoroughly recorded and action had not been taken to reduce risks.

Staff had not been trained or assessed to carry out key tasks for people such as medicine administration or supporting them with catheter care.

Staff did not have access to adequate supplies of personal protective equipment (PPE). The service did not have sufficient infection prevention and control measures in place. Government guidance in relation to COVID 19 was not followed.

Safeguarding concerns had not been reported by staff and management. The registered manager was not clear of their role and responsibility in relation to safeguarding.

Regular deep cleaning regimes were not in place and areas of the home such as the laundry and sluice were dirty and cluttered.

Medicines had not been managed safely. Staff had not received appropriate training and competency assessments. Guidance from other professionals had not been followed.

Quality assurance processes were in place to monitor the quality and safety of the service, but these did not identify serious concerns we found and contradicted practice we observed. There was a clear lack of provider oversight and they had not ensured effective and competent management was in place.

Some staff members we spoke with raised concerns about the management of the service.

We did observe people appeared comfortable and happy with staff interaction with them.

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

Rating at last inspection
The last rating for this service was good (report published 19 October 2019.)

Why we inspected
Serious whistleblowing concerns were received by the local authority safeguarding team in relation to management of the service and the quality of care and support that was being provided. There had been a number of safeguarding concerns raised by other professionals. As a result, we carried out a focused inspection to review the key questions of safe 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 have found evidence that the provider needs to make substantial improvements. Please see the safe and well-led sections of this full report.

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

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 the safety of people and the risk of harm. We also identified breaches in relation to the management and monitoring of the service, premises and equipment and staffing at this inspection.

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

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 continue to monitor information we receive about the service and we will continue to work with partner agencies. We will also request a specific action plan to understand what the provider will do immediately to ensure the service is safe. We will work alongside the provider and the local authority to closely monitor the service. We will return to visit in line with 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?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-led findings below.

Oak Lodge

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 consisted of two inspectors. One pharmacy inspector also reviewed medicine records remotely.

Service and service type
Oak Lodge 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. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
We gave 24 hour's notice of the inspection visit due to current COVID-19 restrictions.

What we did before the inspection
We attended multiple safeguarding meetings held by the local safeguarding team following whistleblowing concerns that were raised about the service.

We reviewed information we had received about the service since the last inspection. We spoke with local safeguarding authority team members and service commissioners. This information helps support our inspections. We used all of this information to plan our inspection.

During the inspection

We spoke with four people, the registered manager, deputy manager, two senior care workers, and four care staff members both on inspection and after the inspection during telephone interviews.

We reviewed, four care plans, five Medicine Administration Records (MARS), two staff files and a variety of records relating to the quality of the service.

During staff telephone interviews, the inspectors received information raising concerns about the delivery of the regulated activity. These concerns were about specific individuals and we have shared them with the local safeguarding authority for action and investigation where appropriate.

After the inspection
We requested further information from the registered manager and nominated individual for the provider.

We shared the concerns we found with the local safeguarding team and various commissioning authorities of those people where we identified as being the highest risk.

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

- The provider did not always keep people safe from the risk of abuse. Staff members concerns about alleged abuse had not always been fully investigated or alerted to the local authority safeguarding team. Staff told us about some of these concerns when we inspected the service.
- The provider had policies and procedures to deal with allegations of abuse but staff did not follow these consistently.
- Staff had completed safeguarding training but a culture had developed where safeguarding concerns were not raised.

The provider failed ensure systems and processes were in place to keep people safe from the risk of abuse. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Infection control

- People were not protected from the risk of infection.
- The provider had failed to implement and follow COVID-19 guidance to reduce the risk of infection. For example, we saw insufficient supplies of Personal Protective Equipment for staff, staff were not following basic hand hygiene procedures and social distancing was not being followed .
- Infection control audits were in place. However these raised no concerns regarding the dirty laundry and sluice, poor practice we observed and the lack of PPE we found.
- The registered manager had assured the CQC, the local authority and infection control nursing team in telephone discussions that they had appropriate supplies and were following government guidance relating to COVID-19 practice.

The provider failed to maintain standards of hygiene relating to premises and equipment. This was a breach of Regulation 15 (Premises and equipment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely

- Medicines had not been administered safely.
- Staff with the required medication training were not always on duty. This had resulted in staff, who had not received appropriate training or had their competencies assessed, were administering medication.
- Instructions provided by other professionals with regard to medicines had not been followed. For example, one person's care plan lacked detail on how oral medication was to be administered via thickened

fluids. This meant the person was at risk of not receiving the right nutrition and prescribed medicines.
● We witnessed staff administering medicines without using any safe infection control procedures. They did not wash their hands prior to administering medicines and did not wear appropriate PPE.

The provider failed ensure the proper and safe management of medicines. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management
● Risks to people had not been appropriately managed.
● We found a lack of hot water in a toilet where staff told us this was where they washed their hands in between providing care.
● Where risk assessments were in place these had not been routinely reviewed or updated. For example, one person did not have a risk assessment in place for self-administering their own medicines.
● Where people required specialist diets, appropriate risk assessments were not in place. Care plans contained conflicting information in regard to the consistency of food people required.

The provider failed to assess the risks to the health and safety of people and do all that is reasonably practicable to mitigate any risks. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Learning lessons when things go wrong
● Systems and processes were not in place to ensure lessons could be learnt when things went wrong.
● Accidents and incidents had not been fully recorded or investigated by management.

The provider failed to assess the risks to the health and safety of people and do all that is reasonably practicable to mitigate any risks. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Staffing and recruitment
● Sufficient staff were available, but staff were not always skilled and experienced to deliver individual's needs.
● The provider failed to ensure the registered manager and staff had adequate knowledge of the service and risks to individual's health and wellbeing. For instance, staff did not receive the appropriate training or have opportunities to develop their skills and knowledge.

The provider failed to ensure suitably qualified, competent, skilled and experienced staff were deployed at the service to meet the needs of people using the service and keep them safe at all times. This is a breach of Regulation 18, (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff recruitment procedures were in place. At the last inspection there were no issues raised around the recruitment of staff. Due to the risks identified during the inspection, we did not complete a review on staff recruitment.

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 registered manager did not understand quality performance, risk and regulatory requirements.
- Quality assurance processes were in place and were carried out, but they did not identify concerns we found. The lack of systems and processes in place to identify concerns or shortfalls within the service placed people at increased risk. For example, lack of staff training care relating to medicines administration and failure to ensure appropriate infection prevention control measures were in place.
- The provider failed to ensure there was effective and competent management arrangements in place. They had a lack of oversight of how the service was being run. They did not have adequate monitoring systems to identify significant shortfalls within the service.

The provider failed to ensure systems and processes were in place to assess, monitor and improve the service. This was a breach of Regulation 17, (Good governance), of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Continuous learning and improving care

- Investigations and auditing of incidents and accidents were not always robust, fully completed or managed appropriately to mitigate future risks to people.

The provider had failed to reduce or remove risks where possible which had a negative impact on people using the service. This was a breach of Regulation 17, (Good governance), of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

- A person-centred culture was not promoted. Some staff told us they felt unable to raise concerns as they felt their confidentiality would not be upheld.
- Staff did not feel supported within their roles. They had not been provided with sufficient training to ensure they had the skills and knowledge they needed. They expressed concerns over the lack of management within the service.
- At the start of the COVID-19 pandemic, the registered manager was only at the service in a part-time capacity. There was not consistent leadership for the staff team at this time.

The provider failed to ensure suitably qualified, competent, skilled and experienced staff were deployed at the service to meet the needs of people using the service and keep them safe at all times. This is a breach of Regulation 18, (Staffing) 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

- The provider had not been responsive to issues and concerns. They had failed to be open, honest, and apologise to people when things went wrong.
- The provider failed to report concerns in relation to COVID-19 to the local authority in a timely manner to enable appropriate, additional support to be provided.

The provider failed to seek and act on feedback provided or concerns raised. This was a breach of Regulation 17, (good governance), of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others

- The service had not engaged with partners.
- The service had been offered support throughout the COVID-19 pandemic from the CQC, the local authority and infection and prevention control nurses. All partners were led to believe from the registered manager there were no issues with the service understanding and following guidance and having the appropriate supplies such as PPE.
- Care plans and risk assessments only contained basic information which meant people's views and preferences about how they wanted their care to be given were not always taken into consideration.
- Professionals visiting the service expressed concerns over the care and support people were receiving.

The provider failed to ensure the care and treatment was appropriate, met people's need and reflected people's preferences. This was a breach of Regulation 9, (person-centred care), of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 9 HSCA RA Regulations 2014 Person-centred care The provider failed to ensure the care and treatment was appropriate, met people's need and reflected people's preferences.

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 failed to ensure systems and processes were in place to protect people from the risk of abuse.