Oak Cottage Care Limited

Oak Cottage

Inspection report

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Date of inspection visit:
08 November 2023
15 November 2023

Date of publication:
20 February 2024

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Oak Cottage is a residential care home providing accommodation for up to 25 people who require personal care. The service provides support to older people living with dementia and mental health support needs. At the time of our inspection there were 17 people using the service of which 10 people received personal care.

People's experience of the service and what we found:
People were not always protected from the risk of abuse. Incidents were identified and reported, but not investigated or reported to the local authority. There was not always evidence of learning following incidents. However, people told us they felt safe.

People said staff were not always deployed appropriately to support them when needed. Medicines management required improving to ensure people received their medicines. Risks were not always fully assessed and documented. Improvements were needed to some infection controls practices and maintenance of the property in the service.

People's health needs were not always fully planned for, so staff did not always have detailed guidance. Staff told us they received training, however we found key gaps in their training records. Some areas of the service needed refurbishing to meet the needs of people living there.

Feedback about the food provided to people was mixed. The chef did not have the required training to support people's specific dietary needs. Weights had not been monitored as required, and fresh fruit and snacks were not always available.

People were not supported to have maximum choice and control of their lives. Staff did not always 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. Although we did see staff asking people consent before supporting them.

Quality assurance systems in place were not effective at monitoring the quality and safety of people's care. Notifications were not always submitted as required. People did not feel the management team were visible or responsive to them.

People were able to access healthcare professionals as needed and staff knew people's support needs well. Staff were seen to be caring and attentive in their approach and had formed positive, friendly relationships with people. Staff felt they worked well as a team and felt supported by the management team. The registered manager was open to feedback and eager to make improvements through the inspection.

Rating at last inspection and update
The last rating for this service was requires improvement [published 11 April 2019] and there were breaches of regulation. The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection we found the provider remained in breach of regulations.

The last rating for this service was requires improvement (published 11 April 2019). This service has been rated requires improvement on 4 out of 5 previous inspections since 04 February 2015.

Why we inspected
We undertook this focused inspection to check they had followed their action plan and to confirm they now met legal requirements. This report only covers our findings in relation to the key questions safe, effective and well-led which contained those requirements.

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating. The overall rating for the service has remained requires improvement. This is based on the findings at this inspection.

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

Enforcement and Recommendations
We have identified breaches in relation to staffing, consent, safe care and treatment, staff support and governance arrangements at this inspection.

Follow Up
We will request an action plan from 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 continue to monitor information we receive about the service, which will help inform when we next inspect.

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 always Safe. Details are in our Safe findings below.	**Requires Improvement**
Is the service effective? The service was not always Effective. Details are in our Effective 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 Cottage

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Health and Social Care Act 2008.

Oak Cottage is a 'care home'. People in care homes receive accommodation and personal care as a single package under one contractual agreement dependent on their registration with us. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Inspection team
The inspection team consisted of 1 inspector.

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was a registered manager in post.

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 professionals who work with the service. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We spoke with 5 people who used the service. We spoke with 8 staff members including, the registered manager, care manager, deputy manager, representative of the provider the chef and care staff.

We looked at 3 people's care records, including risk assessments and medicines records. We also looked at quality audits, policies, training records and staff recruitment files.

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.

Requires Improvement

Is the service safe?

Our findings

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

At our last inspection we rated this key question Requires Improvement. At this inspection the rating has remained the same. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Assessing risk, safety monitoring and management; Using medicines safely

- Medicines were not always safely managed or administered. For example, 1 person's medicine to manage their epilepsy was 12 tablets over the recorded stock level. This suggested they had been signed for but not given and had not been identified though weekly audits.
- A second person had their tablets cut by staff in half. Splitting a tablet can alter its absorption and efficacy. The physical count showed an additional 5 tablets in stock. When we looked at the label of the medication administration record [MAR], this differed from the label on the medicine box. This increased the chance this person may be administered too much medicine.
- People's current needs and risks were not always clearly assessed and managed. People who may display distress did not have this reflected in their care plans to guide staff how to support this person during these times. Specific mental health conditions were not robustly assessed to instruct staff how to positively intervene following recognised interventions.
- Not all risk were assessed for people who had specific conditions. For example, 1 person who had their diabetes managed with insulin had no information for staff around when they may be unwell. For example, around lifestyle, diabetes control and warning signs, eyecare and footcare.
- Some people told us that they had not been consulted about their care plan or wants and wishes. Those people were not clear on why they were living at Oak Cottage and what the plans were for their longer term future.

Although we found no person had experienced harm, risks to people were not always assessed and planned for, and medicines were not always managed safely. This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- However, staff spoken with and observed during our visit knew people's care and support needs well, and the manner in which they supported people was carried out in a manner that met their needs.
- MAR's recorded people's allergies and their medicines were regularly reviewed by the appropriate health professional. Daily checks recorded areas such as room and fridge temperatures and records were maintained for medicines received and returned / destroyed.

At the last inspection, the provider had not ensured the premises were safely maintained. This was a breach of Regulation 15 [Premises and equipment] of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection enough improvement had been made and the provider was no longer in breach of this regulation.

- Window restrictors had been fitted to windows where needed and were being used to minimise the risks of people falling from windows. We have reported in the effective domain where improvements are required

to ensure the environment meets the needs of people.
● Equipment was in place to reduce risk such as sensor mats, pressure relieving cushions and walking frames.
● The safety of the premises was monitored, and staff regularly carried out fire safety checks. People had evacuation plans in place to leave the building safely in the event of an emergency. A fire risk assessment had been completed and those actions arising were being addressed.

Systems and processes to safeguard people from the risk of abuse
● Systems were not effectively managed to identify potential instances of abuse. For example, 1 person was found to have an unwitnessed fall. Staff completed the incident report, but this was not reviewed by a manager and did not appear in the incident log.
● A second incident records staff knocked a person's foot on the wall when transferring. A small skin tear was reported, but managers did not investigate or carry out competency to ensure the staff member was working safely.
● We found incidents of potential abuse which had not been referred to the local safeguarding authority. The registered manager had not been fully aware of their responsibility to report concerns. In addition, 2 medicine errors were reported to the safeguarding team at the local authority in response to our inspection

This meant people may not always be protected as timely action was not always taken to review, respond to and report incidents to keep people safe. This is a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People said they felt safe living at Oak Cottage. One person said, "It is safe here, there is nothing like that to worry about." Staff received training and knew how to keep people safe. One staff member said, "It means we keep them safe; things are done appropriately. I would report if one of the staff try to maltreat the resident, that is an example of safeguarding. If I see a bruise, I record in the incident book, and I report as an incident and inform my line manager. I report to the manager, then if they do not act, I report to the CQC or the Police of social workers."

Staffing and recruitment
● The service did not deploy enough staff to meet people's needs or in line with the outcome of the providers own dependency tool assessment. A dependency tool collates information about each person in receipt of care and support and calculates how many hours of staff support they need.
● Staff were not deployed across both floors and did not always respond to people in a timely way. One person said, "One time, I did buzz, and no one answered so I came downstairs, and they were all busy." A second person said, "They are short staffed, agency come in and we know of them, but they don't know us. They swap them about quite a bit."
● People said at times they had to wait for support when they used their call bell. One person said, "If I ring my bell, they say wait a minute and then I have to wait sometimes it's an hour later."
● An assessment of staffing levels based on people's support needs had not been completed since April 2023. This assessment produces a score that identifies people's level of dependency and gives an indication of the staffing hours required. We asked the management team to urgently review staffing. Feedback from staff and people showed staffing deployment was not sufficient at peak times. The management team immediately reviewed the deployment in the home. And?
● Call bell records record the time it takes for staff to respond to people's request for assistance. Logs reviewed showed significant delays. People experienced delays regularly of 20 minutes or more.

There were not sufficient numbers of staff deployed to enable them to meet people's needs. This was a

breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection

● Towels were found in shared communal bath and shower rooms and not stored in cupboards or people's rooms. We could not be certain that these were not shared between people.

● Some areas of the home were tired and in need of repair to ensure they could be thoroughly cleaned. For example, tiles were missing from the walls of a bathroom, holes in the wall left unfilled and peeling paintwork all presented a risk.

● People said they were satisfied with the cleanliness of the service. Despite the issues raised in shared spaces, we saw people's bedrooms were clean, decorated and personalised. One person said, "It is clean enough, there are the housekeepers who do a good job with cleaning, they are always around tidying and washing things down."

● We saw staff used personal protective equipment [PPE] when providing personal care and policies were in place to manage outbreaks effectively and in line with Government guidance.

Visiting in care homes

● At the time of our inspection there were no restrictions on visiting within the home.

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 our last comprehensive inspection in March 2019, we rated this key question requires improvement. At this inspection the rating has remained the same. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Staff support: induction, training, skills and experience
At the last inspection, the provider had not ensured all staff received appropriate training and professional development to enable them to carry out their roles. This was a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
Not enough improvement had been made and the provider remained in breach of this regulation.

● There was a system of induction for new staff who completed training in key areas. However, formal ongoing competence of staff skills in areas such as care delivery and safe moving and handling were not carried out.
● Staff continued to lack sufficient training around the needs of people including dementia and mental health. Staff were not supported to understand how to positively support people with those specific needs. The chef had not undertaken specialist training to support people's dietary needs. For example, when asked about fortifying people's meals they were unable to explain how and why they would carry this out. Fortifying food is a method used to increase the calorific content of a meal.
● We saw no evidence of that staff were enabled where appropriate to obtain further qualifications appropriate to the work they perform.
● Individual supervision meetings with staff did not happen regularly. One staff member said, "We don't really sit down often with the manager, but we do talk at the beginning of the shift and do handover, which is the supervision." This meant staff were not given the opportunity to regularly review their performance, discuss issues or develop their skills and knowledge.

The failure to ensure staff were suitably trained and supervised in their role was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

● We found the service was not working within the principles of the MCA and if needed, appropriate legal authorisations were not in place to deprive a person of their liberty. Some people had restriction in place without the legal authority to do so. MCA processes had not always been followed.

● The registered manager told us 2 people were supported by staff on a 1 to 1 basis. They said this was to keep them safe. One person had 1 to 1 support because a relative requested and paid for this, and a second person to stop them leaving the home. There was no evidence that capacity assessments and best interest decisions had taken place. DoLS applications had not been submitted and these people were not legally deprived of their liberty.

● Some relatives had not evidenced they held a lasting power of attorney to make decisions on people's behalf. This meant we were not assured decisions for those people were made in their best interest by a person who had the legal entitlement to make those decisions.

●People who were deemed to lack capacity and had no family representation had not been referred for advocate support.

Suitable arrangements were not in place to gain consent from people or those acting on their behalf in accordance with the requirements of the Mental Capacity Act 2005. This was a breach of Regulation 11 (Need for consent) 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

● People's needs and choices were not always appropriately assessed in line with best practice guidance, standards and the law. Some people told us that they had not been consulted about their care plan or wants and wishes.

● People were not always supported appropriately when their needs were changing. Not all people who could experience distress, anxiety or aggression had appropriate robust behavioural plans in place to ensure they were supported in a positive and least restrictive way when they became distressed.

Supporting people to eat and drink enough to maintain a balanced diet; Staff working with other agencies to provide consistent, effective, timely care

● People's weight was not monitored regularly, and staff had not assessed trends in weight loss. Staff did refer people to health professionals when needed, for example where people were at risk of choking.

● Staff did not know which people were at risk of weight loss. For example, the chef told us no person had lost weight in the service. We looked through weight records and found several people had lost weight, the greatest loss in excess of 4 kilograms. This person was not referred to the GP or dietician for review.

● People said they did not have access to a healthy balanced diet and were not positive about the meals provided. One person said, "The dinners are all the same, they are atrocious. They have 2 chefs and all you get is chicken or mince. They way it is cooked is just awful." The meal record showed a lack of variety with chicken served 4 times and mince 2 times in the same week.

● People said mealtimes were too closely spaced. People said they did not always feel hungry at lunchtime, which meant they did not always eat their full meal. People said they were not provided with fresh fruit and had to purchase their own.

● The chef told us people could choose an alternative, however when they told us the alternate options available, we saw the ingredients needed were not in stock. Kitchen staff did not have training to support people's specific dietary needs.

● We saw evidence of visits from various health care professional including GP's, community nurses, physios and occupational therapists.

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

● The service was generally in good decorative order in most areas. People had personalised their rooms, some of which reflected their personality. There was access to shared outside spaces and a spacious lounge and communal area.

● However, some areas were tired and in need of repair. We saw maintenance needed within communal bathrooms and toilets, damage to walls and woodwork. The hallways did not promote a homely feel with dozens of documents relating to the running of the service adorned on the walls in place of pictures, decoration and wallpaper.

● The home was not fully adapted to meet the needs of the people using the service. The environment did not support people positively to live within the home and find their way around. For example, corridors were featureless, lacking items of reminiscence, appropriate signage, or clearly defined doors to support people to find their own bedrooms. Lighting was not adapted to support people living with dementia to help to avoid confusion and reduce their risk of falls.

● Equipment and facilities were clean and fit for use. People who required specialist equipment to keep them safe had these in place, such as pressure relieving equipment or walking aids.

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 our last inspection we rated this key question requires improvement. At this inspection the rating has changed 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; 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

At the last inspection, the provider had failed to ensure there were effective systems in place to assess, monitor and improve the quality and safety of the service. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection the provider had not made the required improvements and remained in breach of this regulation.

● Well led has been rated requires improvement at the last 4 of the previous 5 inspections. At this inspection there continued to be improvements needed in this area. Improvements from issues identified at the previous inspections were still ongoing. For example, we found staff continued to not have appropriate training to support them in their role and improvements needed to the environment.
● The provider continued to not operate effective systems, which were in place, to assess, monitor, and improve the service provided to people. Issues found during this inspection had not been identified by the provider's own quality monitoring arrangements. For example, weight monitoring, medicines management, staffing and a lack of auditing.
● There was a lack of effective oversight of incidents and safeguarding concerns, and no formal audit to check for any trends, patterns or triggers to mitigate recurrence and share learning among the staff team. Incidents, where safeguarding concerns may have been identified through investigation had not been submitted to CQC or the local authority.
● The management team had not completed the required staffing assessment to understand people's needs and the amount of care they required. Managers had not monitored areas such as call logs to identify delays when people summoned assistance and emerging issues and trends.
● The registered manager had not complied with the Mental Capacity Act or DoLS requirements. This meant some people were living in the care home without those appropriate legal safeguards being in place.
● There was not a clear management structure in place with a lack of clarity around who was responsible for the various leadership tasks. Ineffective delegation and unclear roles meant it was not clear which tasks were being carried out by the registered manager and which by the other managers at the service leading to oversight not being effective. This was clarified and a structure implemented after our inspection and roles were defined.
● The management team did not work from a shared service improvement plan to identify and drive improvements in the service.

● There was no system of external independent scrutiny of the quality of care provided. An unintentional lack of effective leadership and oversight had enabled elements of a closed culture to develop. A closed culture is a poor culture that can lead to harm, including human rights breaches such as abuse. For example, management who are either related or friends, poor application or understanding of the Mental Capacity Act (MCA) and managers failing to monitor the quality of care.

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

● Following our inspection visit the management team advised us of steps they were taking to mitigate risks. This included making changes to staff deployment, additional training in core areas, seeking support from a training and development organisation and implementing improved oversight and monitoring.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● People were not all positive about how the management team engaged with them. One person said, "Management, never see them, always in the office. It is very rare that they come out of the office." A second person said, "I see the managers come in at the beginning of the day, then they go, but they very rarely talk to us about anything meaningful."

● Meetings, to gain people's views were held by the activity co-ordinator and fed back to the management team. Although these meetings discussed areas such as meal planning and activity, people said it would be preferable to have managers present to give feedback.

● Staff meetings were not held regularly; this was planned to restart.

Continuous learning and improving care

● The provider and registered manager had not ensured there had been sufficient learning and actions undertaken since the last inspection.

● The registered manager was developing an action plan to help drive improvements the service which they shared with us after the inspection.

Working in partnership with others

● The team at Oak Cottage worked with health and social care professionals to help ensure people had their support needs met appropriately.

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 11 HSCA RA Regulations 2014 Need for consent Regulation 11 Need for consent Care and treatment of service users had not sought with the consent of the relevant person in accordance with the Mental Capacity Act 2005.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Regulation 12 Safe care and Treatment Care and treatment must be provided in a safe way for service users as assessments for some of the risks of receiving the care or support where not carried out as required. People's medicines had not been managed safely.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Good governance. Regulation 17 The provider failed to operate systems effectively to assess, monitor and improve the quality and safety of the services provided. They had not evaluated and improved their practice to ensure care provided was of good quality and safely met people and staff needs.

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care

Regulation 18 HSCA RA Regulations 2014 Staffing

Staffing Regulation 18 (2) (a) (b)

Staff did not receive appropriate support, training, professional development or supervision and appraisal to enable them to carry out the duties they are employed to perform. Staff were not enabled where appropriate to obtain further qualifications appropriate to the work they perform.