Little Oyster Limited

Little Oyster Residential Home

Inspection report

Seaside Avenue
Minster-on-Sea
Sheerness
Kent
ME12 2NJ

Tel: 01795870608

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We expect health and social care providers to guarantee people with a learning disability and autistic people respect, equality, dignity, choices and independence and good access to local communities that most people take for granted. 'Right support, right care, right culture' is the guidance CQC follows to make assessments and judgements about services supporting people with a learning disability and autistic people and providers must have regard to it.

About the service
Little Oyster Residential Home is a residential care home providing accommodation and personal care for up to 64 people. The service supports people with learning disabilities, autism, physical disabilities and mental health conditions. The main building is arranged across 2 floors with lift access and the service has an annex, bungalows and flats on the same site. At the time of our inspection there were 45 people using the service.

People's experience of using this service and what we found
Right Support:
Medicines were not managed safely. People were supported with their medicines, but systems in place were not robust enough and on occasions the service had run out of a person's medicines. There were gaps and errors in record keeping.

Staff supported people to take part in activities of their choice. People were supported to pursue interests in their local area. People's rooms were personalised and they were supported to move to another part of the service if they wanted to and if it was appropriate. Staff supported people in a clean and well-equipped environment. The service had an ongoing programme of redecoration in progress.

Right Care:
People were not always protected from poor care and abuse. The local authority was in the process of investigating a lot of safeguarding concerns. The provider had policies in place and staff had been trained. Safeguarding concerns were reported to the appropriate authorities and the manager worked with the local safeguarding teams to ensure any issues were fully investigated.

Risk assessments had improved since our last inspection and most gave staff enough information to provide safe care. However, some risk assessments were less detailed and put people at potential risk of harm. Care plans were mainly detailed and people's preferences and choices were documented. There were enough staff deployed to provide support for people. Staff knew people well and understood how to provide safe care.

Right Culture:
Since the last inspection a new manager had joined Little Oyster Residential Home. The manager had implemented new quality monitoring and audit processes and a new care system that gave the

management team better oversight of the care and support provided. These quality monitoring processes were still being embedded.

The manager met with staff daily to share information and ensure staff had the most up to date information. The mechanisms for sharing this information widely amongst the staff team were not robust. Other meetings were held regularly, including a clinical risk meeting. These meetings had not always been effective in ensuring staff had up to date information to provide safe care. Although systems had been introduced they had not been fully embedded into the culture of the service. Staff told us the manager was supportive and approachable.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

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

Rating at last inspection and update
The last rating for this service was inadequate (published 23 March 2023) 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 some improvements had been made and the provider was no longer in breach of some regulations. However, they remained in breach of others.

This service has been in Special Measures since 23 March 2023. During this inspection the provider demonstrated that improvements have been made. The service is no longer rated as inadequate overall or in any of the key questions. Therefore, this service is no longer in Special Measures.

Why we inspected
We received concerns in relation to people's safety, risk assessments and the management of medicines. As a result, we undertook a focused inspection to review the key questions of safe and well-led only.

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 changed from inadequate to requires improvement based on the findings of this inspection. You can see what action we have asked the provider to take at the end of this full report.

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.

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

Enforcement
We have identified breaches in relation to safe care and treatment, managing medicines safely, safeguarding people from harm, good governance and record keeping.

CQC's regulatory response to the more serious concerns found at the last comprehensive inspection can be

found in our last report.

Follow up
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?

Requires Improvement

The service was not always sate.

Details are in our safe findings below.

Is the service well-led?

Requires Improvement

The service was not always well led.

Details are in our well led findings below.

Little Oyster Residential 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 Health and Social Care Act 2008.

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 4 inspectors.

Service and service type
Little Oyster Residential Home is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Little Oyster Residential Home is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

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 not 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, which included monthly reports that the provider had sent CQC as part of their conditions of registration. We sought feedback from the local authority and other professionals who work with the service. The provider was not asked to complete a Provider Information Return (PIR) since the last inspection. A PIR is information providers send us to give some key information about the service, what the service does well and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We spoke with 7 people who use the service about their experience of the care provided. We spoke with 15 members of staff including the manager, deputy managers, team leaders, head of care, support workers and ancillary staff. We observed staff interactions with people and observed care and support in communal areas. We reviewed a range of records, including 17 people's care records, multiple medicine records and risk assessments. A variety of records relating to the management of the service were reviewed including staff files, audits, action plans and meeting notes.

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 inadequate. At this inspection the rating has changed to requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Systems and processes to safeguard people from the risk of abuse

At the last inspection the provider had failed to protect people from abuse and improper treatment. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection, although improvements had been made, the provider remained in breach of regulation 13.

● People were not always protected from the risk of abuse. The local authority had received an excess number of safeguarding concerns since our last inspection, which were being investigated by them. These were related to a variety of incidents including, medicine errors and omissions, staff not following healthcare professional's advice which put people at risk of harm and incidents of violence and aggression between people using the service. Some of the safeguarding investigations had concluded that abuse had occurred. Some had been closed with evidence that abuse had not happened.

Although the provider had made improvements, particularly with the reporting of concerns, people were still at risk of harm. This was a continued breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff were knowledgeable about safeguarding and knew how to report signs of abuse and to whom. Staff were confident actions would be taken if they were to report something.
● The provider had safeguarding policies in place and staff told us they had training in safeguarding. People and their relatives told us they felt safe in the service and liked living there.
● Safeguarding concerns were reported to the local authority and the manager and staff cooperated with investigations. The manager had a comprehensive safeguarding log which included an index and tracker to monitor progress and closure.

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

At the last inspection the provider had failed to protect people from risks related to health needs. Some conditions had not been assessed effectively. Accidents and incidents had not always been responded to and reviewed. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection, the provider had made improvements, although these had not all been fully embedded. This was a continued breach of regulation 12.

● Risk assessments for people who were living with epilepsy were inconsistent. Some epilepsy care plans lacked detail. We discussed this with the manager who said they would take action to review these. Despite this many were highly detailed and included triggers that may lead to the person having a seizure. They included instructions for staff on how to avoid the triggers and actions to take in the event of a seizure. People had seizure monitoring records in place which had been completed.
● Risk assessments for people with diabetes did not always contain enough detail for staff to support people to manage their condition safely. Where people needed their blood sugars checked regularly, this was not always carried out. In one case the service had run out of testing strips. No actions had been taken and the risks had not been identified until this inspection.
● CQC received information of concern before this inspection about staff not having knowledge of people's choking risks and how to support them safely. At this inspection risk assessments for people at risk of choking had improved and the provider had put several measures in place to manage these risks. Modified diets were being prepared by a recognised external company and prepared in accordance with each person's need. The manager sourced external training for staff in the management of dysphagia (swallowing difficulties) and the preparation of meals in accordance with the International Dysphagia Diet Standardisation Initiative (IDDSI). There were IDDSI folders in each area of the service containing guidance from the Speech and Language Therapists (SaLT) on each person's dietary needs. Staff were required to sign to confirm they had read and understood the individual plans. Not all staff had signed this confirmation and there was no robust mechanism for ensuring staff were informed when needs changed so people remained at risk.
● In addition to the choking risks above. The service was using a high number of agency staff on shift particularly at night. Agency staff had also not signed to show they had read and understood IDDSI plans which put people at risk of receiving food and drinks which may not meet their needs and put them at risk of choking.
● The provider had systems in place to record and monitor incidents and accidents. Investigation records were maintained and included sections for lessons learned. The manager kept a lessons learned log and shared lessons learned through regular staff meetings and supervisions. Despite this, there were repeated incidents with medicines management and risks to people. Accidents and incidents were not always analysed to identify and act on any trends or patterns.
● Health and safety checks had been completed including fire safety, window restrictors and checks on equipment used to support safer moving and handling. However, the provider failed to follow relevant guidance in relation to preventing bacterial infections in the service's water systems.

Although the provider had made improvements, some risk management practices were still being embedded within the service, placing people at potential risk. This was a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People at risk of constipation had risk assessments and care plans in place, which contained guidance for staff. Monitoring charts were maintained and medicines were given as necessary. Records showed staff sought advice in accordance with the person's care plan. The service was supported by district nurses where treatments were outside the scope of support workers.
● People had been referred to dieticians where there was a concern about weight loss. Records showed staff complied with the nutritional plans provided.

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)

At the last inspection the provider failed to ensure people's rights were upheld within the basic principles of the MCA. This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection, the provider had made improvements and were no longer in breach of regulation 11.

● We found the service was working within the principles of the MCA and if needed, appropriate legal authorisations were in place to deprive a person of their liberty. Any conditions related to DoLS authorisations were being met.
● People had decision specific capacity assessments for example, for the use of restrictive practices such as bed rails or chair restraining straps. Best interest decisions were made where people lacked the capacity to make their own decisions. These were supported by family members and professionals.

Using medicines safely

At the last inspection the provider had failed to ensure medicines were managed safely. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection although improvements had been made the provider remained in breach of regulation 12.

● People usually received their medicines safely and as prescribed. However, systems in place meant that medicines were not always available to people at the start of a new medicines cycle. The service failed to ensure alternative medicines or equipment was sought in a timely manner if it had failed to be delivered. This could lead to people experiencing negative outcomes due to being without prescribed medicines or diagnostic equipment for an extended period.
● Medicines were stored securely. However, medicines were not always being stored at the manufacturers recommended temperature as required by the provider's policy.
● Medicines administration records were sometimes incomplete. Gaps in records were sometimes present either due to staff failing to fill in the record or the system becoming disconnected from the internet and failing to record. The service had managed to mitigate the risk of inaccurate records by introducing a daily stock check which allowed them to follow up gaps and ensure that people had in fact received their prescribed medicines even if the system did not indicate this.
● Changes to people's medicines were not clearly communicated to staff. This could potentially lead to delayed or missed treatment due to staff having no clear record where changes were made and when they were to be implemented.
● Where staff manually made entries to the electronic medicines administration system (e-MAR) there were sometimes inaccuracies. Spelling mistakes for prescribed medicines and unclear doses could lead to confusion, especially during transfer of care to another healthcare provider.

The provider did not have robust systems in place for the management of medicines. This was a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

● There were enough staff deployed to meet people's needs. The service used a dependency tool, which helped the manager to calculate the number of staff needed. Rotas showed that planned shifts were filled.
● Staff had been recruited safely. Records were maintained to show that checks had been made on employment history, references and with the Disclosure and Barring Service (DBS). DBS checks provide information about convictions and cautions held on the Police National Computer. This information helps employers make safer recruitment decisions.
● Regular agency staff were deployed to fill gaps in the rota. Agency staff profiles were in place to ensure they had been recruited safely and had received relevant training.

Preventing and controlling infection

● We were assured the provider was preventing visitors from catching and spreading infections.
● We were assured the provider was supporting people living at the service to minimise the spread of infection.
● We were assured the provider was admitting people safely to the service.
● We were assured the provider was using PPE effectively and safely.
● We were assured the provider was responding effectively to risks and signs of infection.
● We were assured the provider was promoting safety through the layout and hygiene practices of the premises.
● We were assured the provider was making sure infection outbreaks can be effectively prevented or managed.
● We were assured the provider's infection prevention and control policy was up to date.

Visiting in care homes

Visiting was unrestricted. We saw visitors coming and going freely during the inspection.

Requires Improvement

Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At our last inspection we rated this key question inadequate. At this inspection the rating has changed to requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

At the last inspection the provider had failed to operate a robust quality assurance process to continually understand the quality of the service and ensure any shortfalls were addressed. The provider had not maintained accurate and complete records in relation to the service and people's care. This was a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection, although there was some improvement in the quality assurance processes, the provider still failed to maintain accurate and complete records in relation to people's care. The improvements had not all been fully embedded within the service and the provider remained in breach of regulation 17.

● There were still some gaps in medicine recording and although the service had a Medicines Communication book, this had not been used. Medicine audits had identified some shortfalls and an action plan was in place to address these. New medicine competency assessments were in use. There was a plan to introduce electronic medicine records once the infrastructure in the service was deemed suitable. This would improve medicine recording and minimise the risk of medicine errors.
● Since our last inspection there had been improvements in documenting people's nutrition and fluid intake. We saw people had been offered more fluids during the hot weather. However, records were still inconsistent, for example, meal records did not always detail how much or what the person had eaten. Some fluid intake recording remained inconsistent.
● Maintaining accurate records remained a concern across the service. Staff did not always document in the care records at the point of care delivery. Recording of some elements of a person's care was inconsistent. One person's record showed oral health care had been provided 6 times in 26 days. A concern was raised during our inspection about a person not wearing the correct footwear. Senior staff had not identified this as a risk and although staff rectified this, they failed to document the incident. Other elements of recording, for example, blood sugar monitoring, epilepsy care plan and seizure diaries were also inconsistent.
● At the time of our inspection the service did not have a registered manager. A new general manager was in post and was working towards the improvements required. The manager had taken steps to improve the oversight of the service through regular meetings, monitoring and audits. The front page of the new electronic care system provided the manager with an overview of care delivered and anything outstanding. The system provided management alerts to support oversight.

● The new manager had introduced an audit programme with regular audits being allocated to members of the management team. Shortfalls highlighted during audits were transferred to an ongoing action plan. The action plan identified the staff accountable for the actions and the timeline for completion. The action plan was updated regularly as actions were taken and issues resolved. Some audits required reviewing and amending as they were not robust enough to identify the issues captured in the inspection. For example, the management team had completed a daily check of the IDDSI folders in each of the units but had not picked up that staff on shift had not read and signed the guidance, agency staff had not read and signed the guidance and when guidance had been reviewed and amended by healthcare professionals that staff had not re read and signed the updated guidance.

Failure to maintain accurate and complete records and operate a robust quality assurance process to continually understand the quality of the service and ensure any shortfalls were addressed in relation to people's care was a continued breach of Regulation 17 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

● Services providing health and social care to people are required to inform the CQC of important events that happen in the service. This is so we can check that appropriate action has been taken. The manager had correctly submitted notifications to CQC.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
● The manager had created a new management structure and had deployed an experienced care manager to provide additional support, mentoring and guidance to the team. Each area of the service had a team leader in place. There was active mentoring in place for the deputy manager and team leaders and an increase in face-to-face training to foster improved teamwork. However, the manager was aware further work was needed to fully embed some of the improvements.
● People we spoke to told us they liked living in the service and were happy there. One person told us they were looking forward to the afternoon activities.
● Staff told us they liked working in the service and the new manager was supportive and approachable. Staff told us the new systems being implemented were good. One staff member told us, "This is the best I've seen it for 6 years."

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others
● The service did not always work well with other professionals and this lack of good partnership working had a negative impact on people.
● The manager had weekly clinical risk meetings with the head of care, deputies and team leaders. This was an opportunity to discuss outstanding actions from previous meetings as well as new issues in relation to a variety of clinical areas, such as wounds, infections and medicines. Information was gathered daily from each area of the service, which was used to inform the agenda for the clinical risk meetings. Daily staff meetings with all heads of departments aimed to ensure staff were kept up to date with any changes.
● Despite these meetings, important messages were not always communicated to staff effectively to ensure people's care was safe. For example, not all staff were made aware of changes in people's medicines or when people's care needs or risks changed. The new care system had a facility for communicating handover information which contained an audit trail. The manager told us they would be implementing this once all staff had been fully trained in the new system.
● The provider had systems in place to ensure people were able to give feedback about the service and their support. The resident of the day system was still in place. This was an opportunity for staff to spend time

with the person who was 'resident of the day' to review their support plan and ensure their needs were still being met. We saw actions taken in response to feedback. For example, people had moved to other parts of the service at their request where this was possible.

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 Care Quality Commission (CQC) sets out specific requirements that providers must follow when things go wrong with care and treatment. This includes informing people and their relatives about the incident, providing support, truthful information and an apology when things go wrong. The provider understood their responsibilities.

● It is a legal requirement that the latest CQC inspection report rating is displayed at the service where a rating has been given. This is so that people, visitors and those seeking information about the service can be informed of our judgements. The provider had displayed a copy of their rating in the service and on their website.

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 12 HSCA RA Regulations 2014 Safe care and treatment The provider failed to implement and embed robust risk assessments in relation to people's health needs. This put people at potential risk of harm. The provider failed to ensure medicines were managed safely.

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 people were protected from avoidable harm and abuse.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to maintain accurate and complete records in relation to people's care.