

Oak Health Uk Ltd

Oakdene Rest Home

Inspection report

165 Minster Road
Minster On Sea
Sheerness
Kent
ME12 3LH

Tel: 01795874985

Date of inspection visit:
20 September 2016
21 September 2016

Date of publication:
12 December 2016

Ratings

Overall rating for this service

Requires Improvement 

Is the service safe?

Requires Improvement 

Is the service effective?

Good 

Is the service caring?

Good 

Is the service responsive?

Requires Improvement 

Is the service well-led?

Requires Improvement 

Summary of findings

Overall summary

The inspection took place on 20 and 21 September 2016. The inspection was unannounced.

Oakdene rest home was registered to provide accommodation and personal care services to 26 older people. 17 people were living at the home on the day of our inspection.

Oakdene rest home was situated on the Isle of Sheppey in a central location. There were two floors in the home providing care and support to older people with varying needs, many of who were living with dementia. Access between floors was via stairs or a chair lift so only people who were independently mobile were accommodated in the five upstairs bedrooms. There were two lounge areas for people to sit in or to take part in activities. One lounge led onto a garden area where people could sit out in fine weather if they wished. There were no en-suite bedrooms, people shared bathroom facilities. Some people chose to eat their meals in a small pleasant dining area.

We last inspected this service on 12 and 14 October 2015 when we found three breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These breaches were in relation to Regulation 12, Safe care and treatment and Regulation 15, Safety and suitability of premises. Following the inspection the provider did not send an action plan to inform us how they intended to improve the service and meet the requirements of the regulations.

However, at this inspection we found that the provider had taken action to address the breaches from the previous inspection and had made some improvements to the service provided. Improvements had been made to managing infection control measures and the safe management of medicines. Improvement was still required to adequately assess risks to the health, safety and welfare of people receiving care. A new registered manager was in place who was addressing the areas of concern.

There was a registered manager based at the service who had taken her post since the last inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People and their relatives told us they felt safe living at the home. They told us who they would speak to if they were worried about anything and were confident they would be listened to. We spoke to staff who were able to tell us how they kept people safe. They understood their responsibilities in ensuring people were safe from abuse and their role in reporting any concerns they had. There was evidence that staff had previously raised concerns with the local authority and CQC, helping to keep people safe.

Risks to people's safety and wellbeing were not always managed effectively to make sure they were protected from harm. The care home did not have all associated individual risk assessments in place to

identify and reduce risks that may be involved when caring for people in the home.

Fire evacuation drills had not been undertaken to make sure staff understood the fire evacuation procedure and how to implement it. Personal emergency evacuation plans were not in place for individual people to guide staff how to support people appropriately in such an event.

There were not sufficient numbers of staff deployed effectively to meet the needs of people living at the home. Staff were expected to carry out a number of other tasks around the home as well as their primary responsibility of supporting people. This meant there were not always enough staff available when required to assist people.

There were no activities plans in place in order to ensure people were meaningfully occupied with activities that matched their hobbies, interests and preferences. Activity records showed the activities on offer were limited. An activities coordinator had been recently recruited to provide more opportunities for people.

There were no regular monitoring and auditing processes in place to check the quality and safety of the service provided. Some auditing mechanisms were in place, however these had not been carried out at the correct regular intervals. Surveys had not been undertaken to hear people's views and use the information from them to improve the service.

The provider's whistleblowing policy did not include how staff could raise a concern outside of the organisation should they have concerns they felt were not being dealt with by the provider. We have made a recommendation about this.

Medicines were managed well by staff who were trained and competent to administer people's prescribed medicines safely.

The home was maintained reasonably well, however it was in need of updating. The provider was in the process of decorating bedrooms and changing the flooring in the communal areas. The main lounge area was quite dark and dull with little natural daylight which could impact on people's abilities to undertake activities and on their well-being. We have made a recommendation about this.

The provider used safe recruitment processes when employing new staff to make sure only suitable staff were employed to work with people. The registered manager had a training plan in place and all staff received the training they required to carry out their role well. There had been a lapse in staff receiving regular supervision and appraisal due to the change in management, however, the new registered manager had a plan in place that had already commenced.

People's care needs were assessed before moving into the home to make sure the registered manager was confident the staff team had the skills to support people well. The registered manager was in the process of changing the paperwork for care plans to make them more person centred.

People's relatives told us they had not been involved in reviewing their loved one's care plans. We have made a recommendation about this.

People were complimentary about the food and the choices they were given. People could choose something different to the choices on the menu if they wished. People's specialist nutritional needs were catered for and well recorded.

People were supported to look after their health. Health care professionals were contacted and their advice sought to ensure people got the care and support they required to maintain their health and well-being.

People's relatives said they would be happy to take any concerns they had to the registered manager. Staff were complimentary about the new registered manager and the improvements she had already made. They said they would raise their concerns with her and were confident she would act on them.

During this inspection, we found four breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of this report.

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 safe.

Individual risk assessments were not always comprehensive or person centred.

Fire safety planning and risk assessing was not robust enough to keep people safe from harm in the event of an evacuation.

There were not sufficient staff deployed to ensure people always got the care and support they required.

Medicines were managed well ensuring people received their prescribed medicines safely.

The provider had safe recruitment processes in place to make sure only suitable staff were employed to care for people.

Is the service effective?

Good 

The service was effective.

Staff had the appropriate training and support in order to carry out their role well.

The registered manager was guided by the principles of the Mental Capacity Act 2005 to make sure people's right to make choices and decisions were adhered to.

People's specialist nutritional needs were catered for and there was plenty of choice on the mealtime menus.

People were supported to maintain their health and well-being, staff liaised well with health care professionals.

Is the service caring?

Good 

The service was caring.

Staff knew people well and chatted with them about their families.

People were treated with dignity and respect and staff could describe how they made sure this happened.

People were encouraged to make choices and these were respected by the staff.

Is the service responsive?

The service was not always responsive.

In house activities and the opportunities to go out were limited.

The registered manager held resident and relatives meetings to share information and hear people's views.

An initial assessment was undertaken with people before moving into the home. Care plans were not always comprehensive.

There was a complaints procedure and people and their relatives knew who to complain to if they needed to.

Requires Improvement 

Is the service well-led?

The service was not always well led.

Regular monitoring and auditing processes were not in place to check the quality and safety of the service provided.

Surveys were not undertaken to gain feedback in order to improve the service.

The registered manager was approachable and listened to concerns raised.

The provider and registered manager had acted openly when concerns had been raised. They had collaborated well with other agencies to make improvements.

Requires Improvement 

Oakdene Rest Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection took place on 20 and 21 September 2016 and was unannounced.

The inspection team consisted of two inspectors and one expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection we asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the home, what the home does well and improvements they plan to make.

Prior to the inspection we also looked at previous inspection reports and notifications about important events that had taken place at the service. A notification is information about important events which the home is required to send us by law.

We spoke with nine people who lived at Oakdene rest home and eight relatives, to gain their views and experience of the service provided. We also spoke to the registered manager, two senior care workers and four care staff. Before and after the inspection we gained feedback from three health and social care professionals.

We spent time observing the care provided and the interaction between staff and people. We looked at six people's care files and seven staff records as well as staff training records, the staff rota and staff team meeting minutes. We spent time looking at records, policies and procedures, complaints, incident and accident recording systems and medicine administration records.

Is the service safe?

Our findings

At our previous inspection on 12 and 14 October 2015 we identified three breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Two breaches were in relation to Regulation 12, safe care and treatment and one breach in relation to Regulation 15, premises and equipment. Following the inspection the provider did not send us an action plan to show how they intended to improve the service and meet the requirements of the Regulations.

At this inspection we found there were still some issues around the adequate assessment of risk to the health, safety and welfare of people receiving care. The registered provider had employed a new registered manager who was working through and addressing all areas of concern. Systems were in place to better manage infection control and ensure the safe management of medicines.

Risk assessments did not adequately identify potential individual risks to people when receiving care and support. For example, a risk assessment around the risk of absconding was in place for some people. However, this was a general risk assessment to cover any person who was at risk and did not identify the risk to each individual and how to minimise the risk for that person. Risk assessments had not always been reviewed at the times specified on the risk assessment. For example, one person's risk assessment relating to a mobility aid had not been reviewed since March 2016 although it stated it should be reviewed monthly. Therefore people were not always protected from the risks associated with their specific needs and staff did not have all the information required to keep individual people safe on a daily basis.

Records were kept of incidences of complex or challenging behaviour. These were shared with a specialist health care professional who visited regularly to give advice and guidance to support people on an individual basis. However, we saw that guidelines to give staff the step by step guidance required to make sure each individual was supported with a consistent and suitable approach were not in place. The appropriate guidance for staff was not in place to support people to feel safe when tensions rose between people within the home.

Environmental risk assessments were undertaken to manage risks associated with the premises and environment. A fire risk assessment had been carried out to ensure safe equipment and processes were in place to prevent a fire on the premises. Checking and monitoring of all fire systems and equipment were undertaken at appropriate intervals to make sure they were in good working order. The servicing of fire equipment and alarms had been undertaken and were all up to date. However, no fire evacuation drills had been recorded as having taken place. The provider had no means of knowing how staff would respond to a fire on the premises as the fire evacuation procedure had not been tested. Staff were not given the opportunity to practice and refine the evacuation procedure to be able to keep people safe in the event of a fire. The provider has since arranged dates for fire evacuation drills to take place and to have an independent fire risk assessment carried out. People did not have a personal emergency evacuation plan (PEEP) to detail the individual assistance each person required to evacuate the building safely should a fire break out or other emergency situation take place. The registered manager had started to develop a PEEP for each person although this was in the early stages, we could see that three had been commenced.

All external and some internal doors were fitted with electronic locks which included the fire doors fitted with crash bars. Key fobs were used to unlock the doors fitted with electronic locks which staff had access to. The provider told us the electronic locks would automatically unlock when the fire alarm sounded. However, one of the fire exits to the side of the property was fitted with bolts at the top and bottom so even if the electronic lock was released the door could not be opened. One of the fire exits led into the enclosed back garden, where the gate to the car park was fitted with an electronic lock. This hampered access to the fire assembly point in the car park for people or visitors who did not have access to a key fob. These risks had not been identified through risk assessment or the fire evacuation procedure to reduce the risks of people not being able to exit the premises in the event of a fire.

The main hallway was clear of any obstructions allowing the residents clear safe passage, however the staircases were fitted with stair lifts which restricted the room to walk. The staircase accessing a bedroom in the "annexe" was quite narrow and steep with restricted headroom as well as having a stair lift, further restricting movement. There were no risk assessments in place to minimise the risks of people, staff and visitors using the stairs with the restricted available access. People, staff and visitors were not kept safe from potential hazards regarding the premises as risks had not been fully identified and measures put in place to minimise the risks.

The failure to assess and mitigate individual risks, environmental and fire risks were a breach of Regulation 12 (1)(2)(a)(b)(d) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safe care and treatment.

Sufficient numbers of staff were not deployed to meet the needs of people living at the home. The staff rota indicated four staff were allocated to care for people on each day time shift. One senior care worker led the allocation of tasks on each shift. However, one of the allocated staff on shift was usually the deputy manager, who the staff told us was too busy taking care of their other responsibilities to be able to care for people. Staff said they were told they could ask the deputy manager for help if they needed it but felt this was not effective as the deputy manager was often too busy. We observed the deputy manager had responsibilities other than caring during the inspection. We were told the senior on shift was often carrying out the medicines round or dealing with health care needs such as GP or district nurse visits or on the telephone chasing appointments etc., further reducing the assistance available. A cleaner was employed part time by the provider to take care of cleaning responsibilities. However, these hours did not sufficiently cover every day. This meant that when the cleaning staff member was absent, the care staff were required to undertake the cleaning duties too. On the day of our inspection, the cleaner was off sick and we saw the care staff on duty hoovering and carrying out other cleaning tasks. No laundry staff were employed so care staff were responsible for making sure all the laundry was washed and dried every day. A cook was employed for 30 hours per week and a full time kitchen assistant. In addition, one of the care staff who worked part time also carried out cooking duties for 12 hours per week. The kitchen staff went off duty by mid-afternoon each day so care staff provided the evening meal as well as clear and wash up afterwards. During the inspection we noticed that many times staff were not available in the lounge area to assist people when they needed it as they were busy elsewhere. For example, although jugs of cold drinks were available on the table, people were not able to access a drink when they wanted one as there were often no staff to ask.

The registered manager had a risk assessment in place to support the prevention of challenging behaviour between people living in the home. The risk assessment stated that one member of staff should be present within the lounge area at all times to support people and prevent altercations. However, we noted that there were many times throughout the days we were inspecting when no staff were in attendance in the lounge area as they were busy elsewhere.

The provider had a dependency tool in place intended to assess and plan the numbers of staff required to meet the needs of people living in the home each week. However, it was not easy to understand and the registered manager agreed they had not understood it since they started in post so had not completed it. The provider did explain how the tool worked, however, it was not appropriate to use as a means of assessing and planning numbers of staff required. The tool was completed in retrospect, recording the amounts of staff who had been on duty the previous week and checking that these had been suitable numbers. This meant an appropriate method of assessing people's needs and matching these with numbers of staff required to meet those needs was not in place to ensure safe numbers of staff were available. Relatives commented that they thought there were not enough staff available at times.

The failure to provide sufficient staffing to meet the needs of people living in the home was a breach of Regulation 18(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Staffing.

The people we spoke with who lived at Oakdene rest home told us they felt safe and that they had no concerns regarding their care. Relatives also thought their loved ones were safe living in the home. One relative said, "I'm very pleased with the place, I feel she is safe". Another told us, "The care she gets is OK, we can go away knowing she is in good hands".

Safeguarding concerns had been raised regarding vulnerable adults living in the home. The provider and registered manager had worked closely with the local authority to ensure concerns were addressed and dealt with appropriately. Local authority representatives told us they felt the provider, registered manager and staff had responded in an open manner and were keen to work collaboratively. The registered manager had a comprehensive file with all safeguarding concerns, meeting minutes and actions taken recorded. The guidance and advice staff would refer to about abuse if they had a concern to report was available through a safeguarding procedure. Staff had a good understanding of their responsibilities in keeping people safe from abuse. All staff said they would have no qualms raising any worries they had and they were aware of who to contact outside of the organisation should this be necessary. Staff were encouraged to report suspicions as quickly as possible and had the information available to them to help keep people safe from abuse. People were kept safe by staff who had the information they required to raise any concerns they had about the people in their care.

Medicines were managed safely and staff followed a medicines policy and procedure. A process was in place for the storing, ordering, obtaining and disposing of people's prescribed medicines. We checked five people's Medicines Administration Record Sheets (MARs) for the administration of medicine. These were up to date with no gaps showing and all medicines had been signed for. Some people had "As and when required" PRN medicines. Protocol and guidance was in place for staff to follow which included the dosage, frequency, purpose of administration and any special instructions. The protocol did not include how the person would inform staff if they were in pain such as verbally or through body language. The registered manager told us they would add this to the protocol. We observed staff asking people whether they were in pain before administering any pain relief.

All accidents and incidents were recorded well and monitored by the registered manager to check if there were trends developing. The registered manager kept an analysis of falls each month, monitoring if people had more than one fall and taking action to try to prevent future occurrences. The registered manager had acquired alarm mats for people who were at risk of falls. These would alert night staff if people stepped out of bed so they could quickly assist them to keep them safe. Referrals were made to health care professionals for their expertise when necessary.

The home was reasonably well maintained. A maintenance officer was employed with the responsibility of

maintaining the home. They were supported by a volunteer who helped out at regular times through the week. All essential servicing had been carried out to ensure the safety of the building and equipment. These included portable appliance testing, hoisting equipment, servicing and testing of electric installations and gas safety.

The home was in need of updating, some areas were tired looking. The main lounge area that people used the most was dull and quite dark. People found it difficult at times to be able to carry out activities such as needlework or reading due to the poor lighting and lack of natural light in the lounge area. Lack of sufficient lighting could also have a negative effect on people's well-being. The provider was in the process of decorating the home and changing some of the flooring. Bedrooms were being decorated while they were empty to minimise disruption to people. Carpeting was in the process of being replaced by laminate flooring in the communal and hallway areas.

We recommend the main lounge area, used by most people, be prioritised for refurbishment and the provider researches ways to lighten the area more appropriately.

New staff went through an interview and selection process. The registered manager followed the provider's policy which addressed the things they needed to consider when recruiting a new employee. New staff had been checked against the disclosure and barring service (DBS) records. This would highlight any issues there may be about new staff having previous criminal convictions or if they were barred from working with vulnerable people. People were protected from the risk of receiving care from unsuitable staff.

Is the service effective?

Our findings

People were happy with the food provided and thought they had plenty to eat. The people we spoke to said, "The food is very nice, the staff are all very nice", another said, "The food is good, sometimes I go to the dining room and sometimes I get it brought to my room".

Relatives also said their loved ones seemed happy with the meals. One relative said "She is happy with the food, there is a choice and she loves her puddings".

People could sit in a pleasant dining room that had recently been redecorated. The dining room was small with seating available at tables for up to ten people. Not everyone living at the home would be able to use the dining room if they chose to. Most people therefore ate their meals in the lounge or in their rooms. Seven people sat and ate their meals in the dining room on the days of our inspection.

A health and social care professional had written positive comments when they were visiting. The comments were complimentary about a member of staff and their skill and 'nice approach' when assisting one person to eat their meal. There was a choice of two meals and people could ask for something different if they did not want what was on the menu. Meals were pre ordered on the day with the cook who personally spoke to each person making sure they understood the choices available. One person was seen to request something different for their lunch which was accommodated. The food was served fresh and meals looked appetising and of a good size. Meals were followed by a choice of dessert and accompanied by water or blackcurrant or orange squash. 1950s music was playing which the residents seemed to enjoy and one or two periodically sang along. A relative visiting during lunchtime commented how nice it was to have the music playing and it was the first time they had experienced it in the many years their mother had been living at the home.

The registered manager had used a tool to assess and detect any risk of malnutrition. People who required additional support to maintain their nutrition had care plans in place to inform staff the specific support they required. For example, if people had a fortified diet. Information was stored in the kitchen relating to people's dietary requirements. The cook spoke about the people they cooked for and knew people's likes, dislikes and the form their food should be in. For example, a soft food or puree'd diet. People's weight had been monitored and action taken if staff were concerned that someone had lost weight, such as contacting the person's doctor.

As the home had been without a manager for the first months of 2016, supporting staff through supervision and appraisal had lapsed. However, we could see that the new registered manager had in place a plan to ensure all staff had regular one to one supervision meetings as well as observational assessments. We looked at staff files that showed this plan had commenced and staff now had the opportunity to receive one to one personal development support. One member of staff said, "Supervisions are better now we are having them regularly and I find them useful". Another staff member told us, "They also do things like check our competency with medicines now".

The registered manager had a training schedule which set out the dates of training attended by all staff. This meant she could monitor the training needs of staff and plan accordingly. We could see that all staff were up to date with the training required to carry out their role. Some additional training for specific needs had been available and we saw that other dates were booked for courses such as diabetes and falls prevention.

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. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the home was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. Care plans for people who lacked capacity showed that decisions had been made in their best interests. Care plans demonstrated DoLS applications had been made to the local authority supervisory body in line with agreed processes. This ensured that people were not unlawfully restricted.

Staff liaised well with health care professionals to make sure people received the care they required with their health needs. People were supported to remain as healthy as possible. Records showed that people had been supported with appointments with district nurses, psychiatric nurses and GP's. The registered manager told us about the developments they had undertaken with the community matron. One of these was for anticipatory prescriptions for antibiotics agreed with the matron for those people who suffered with regular infections that had a debilitating effect on their ability to function as normal. The matron had developed a specific care plan for each person it was felt necessary to include. This meant that antibiotics could be held at the home for specific people known to suffer chronic infections. At the first signs of infection staff could liaise with the matron to gain their agreement to start the antibiotics straight away if they felt this was appropriate given the symptoms.

A relative said, "Any changes and they tell me straight away, my mother had an infection and they told me straight away". Another relative told us, "If he needs a Doctor they soon get him and the nurse lady is very good too."

Is the service caring?

Our findings

All the people and their relatives we spoke to felt that the staff were kind and very caring and they spoke to people with respect. One person told us, "It is alright here, the staff do well".

One relative said, "They have been brilliant with my mum, she is much better than she was before she moved in here". Another told us, "Staff are kind and friendly and I have never known them moan about people".

Many people living in Oakdene rest home were living with dementia and would become upset at times if their surroundings became unfamiliar to them. Staff were patient and understood people's individual needs. They knew people's family members and were able to reassure people by talking about specific people in their lives to ease their worry.

Staff acted with kindness and caring towards people and clearly enjoyed supporting people. Staff were observed reassuring a person who was upset. A staff member sat down and spoke quietly to the person which appeared to comfort and calm them. One member of staff said, "I get a real buzz out of making people smile".

Staff knew people well and were aware of their preferences. Many bedrooms were partly furnished with people's own furniture. People had photographs and ornaments in their bedrooms giving a personal touch to their own private space. One relative told us about their loved one, "She loves music and they put it on for her during the evening and getting up in the morning".

The registered manager told us the activities coordinator was starting work on developing people's life stories to add benefit to their care plan information. The life stories would enable staff to have valuable personal information and insight about people. Although a lot of this was known by staff who had been employed for some time, the registered manager thought it was crucial for new or agency staff to have all essential information. It would enable a more holistic approach to people's care and support whoever was delivering this.

The provider had a service user guide that was given to people when they first moved in to the home. The guide gave people and their relatives all the information they needed to know when living in the home. Information such as facilities and services available as well as information about the provider and staff team was included in the guide.

People were treated with dignity and respect throughout the day. We spoke to several people in their bedrooms who explained that they preferred to stay in their rooms, as they were used to and liked being on their own. People told us they had made their own choice about staying in their room. People told us they could have their bedroom doors open or closed, whichever was their preference, some had televisions with remote controls and portable radios. Staff were observed knocking on people's bedroom doors and waiting for a reply before entering.

Staff made sure they handed over information from one shift to the next so that important details about people's day/night and how they were feeling were passed on. This ensured the continuity of people's care was given a priority. One member of staff told us, "When we come on shift we are told about any changes in things like medication, or the way someone is being cared for. They tell us about anyone who is unwell. If someone who has not been drinking enough, they will ask us to encourage fluids when they are awake during the night".

Relatives said they could visit whenever they wanted and for however long they wanted to.

Is the service responsive?

Our findings

An activities coordinator had recently started in post, working 20 hours per week. There had been concerns raised by people, their relatives and staff that people did not have the opportunity to take part in meaningful activities to help stimulate and prevent boredom. People did not have the opportunity to go out of the home for trips out or just walks in the community if this was their preference. One health and social care professional told us, "Activities are lacking and I have concerns about people not going out. The new activities coordinator being in post is a plus and I expect things to change now". One person living with dementia was often quite upset and worried as they felt they needed to be somewhere else, taking care of their responsibilities, not understanding why they were in the home instead. There were few activities to keep this person distracted and occupied to relieve their distress.

An activities board, intended to inform people what activities were available in the current week, was on display in the main lounge area. However, this was not completed, the date had not been changed from the day before and no activities had been added. Only the hairdresser who attended the day before was displayed on the board for the whole week. This meant that people could not check to see what they might like to join in and the wrong day display could confuse people living at the home. Activities were on an informal basis according to the needs of the day, meaning that some people would not be aware what was available or planned. Relatives could not check to see what their loved ones would like to be involved in and be able to offer encouragement and reminders when visiting. Individual people's activities records were kept within an activities file. The activities records were not person centred as they did not have information individual to each person. Most people had the same activities recorded, for example, reminiscing, exercise, sing along, watching a film and pom-pom making. One person who was cared for in their room and did not sit in the lounge area had exactly the same activities recorded within their record each day as those sitting in the lounge area. These included sing along and film watching. Some people's activities records were blank so there was no evidence they had the opportunity to be involved in any meaningful activity. There was no evidence that people's preferences and needs around meaningful activity had been assessed or taken into account when planning people's care. No activities plans were in place to identify people's own hobbies and interests so that activities could be planned around these for the individual. On the day of our inspection we saw two separate group activities, needlework and armchair exercises, that six people joined in with. The six people were all sitting in the lounge area most of the day.

A hairdresser visited every week so people could choose to have their hair cut or washed. We saw the hairdresser was a familiar presence to people and staff and was having a chat with people while attending to their hair.

The failure to assess people's preferences and interests in order to plan and deliver meaningful activity opportunities to people was a breach of Regulation 9 (1)(3)(a)(b) of the Health and Social Care Act 2008 (Regulations) 2014. Person centred care.

People and their relatives told us they knew who to go to if they had any complaints and would feel comfortable doing so. They felt the new registered manager would listen to their complaints and respond.

People and their relatives were given information about how to make a complaint should they need to know, when they moved into the home through the service user guide. The provider's complaints procedure was available on a notice board in the hallway and the contact details of the Local Government Ombudsman if people or their relatives were not happy with how their complaint was handled. One relative told us of an informal concern they raised with the manager which was dealt with correctly and there had been no further concerns since.

People needs were assessed by a member of the management team before they moved into the service. This information was then transferred onto initial care plans to inform staff how to meet people's needs.

Information was not always available to inform staff about how to meet people's needs. Two of the four files we viewed contained limited information and blank documents. The two files that had been completed contained information and guidance to inform staff how people wanted their assessed needs met. These included information relating to personal care, health support, mobility, social and leisure needs and any behavioural support. The registered manager was in the process of changing the paperwork in people's care plans which they said was more person centred than the care plans being used at present. Some people's care plans had been changed over to the new paperwork and we looked at two of these. Staff said it was much easier to follow the new care plans. One member of staff said, "This was our biggest problem, we would struggle to find information. The new care plans are so much better, if you're not sure about something the information is there". The registered manager told us this was still a work in progress but she hoped to have all the care plans transferred to the new format within a timescale.

Reviews of care plans had not been carried out regularly due to the change in management and the changes taking place with care plans. Relatives told us they had not been involved in care plan reviews. One relative said "They let me know if he is having a blood test or blood pressure, but apart from that I don't know what happens". The relatives we spoke to did not appear to be aware of any care plans that were in existence for their loved ones. When we explained this further they felt there may have been a plan when their relative first moved in to the home but were not aware of any updates since.

The registered manager assured us her intention was that people and their relatives would be fully involved in reviews once the new paperwork was in place. She said family members of three people had been invited to their most recent care plan reviews and this would continue for all people and their relatives.

We recommend the registered manager develops a plan to ensure family members or friends are invited to care planning reviews in order to support their loved ones and to provide a valuable contribution to their care.

People and their family members had been able to give their views of the service provided at resident and relatives meetings held twice in the last 12 months. We looked at the minutes of the last meeting, held in June 2016 when a variety of subjects had been discussed. For example, relatives had said how they had seen improvements in the home since the last CQC inspection in 2015. The state of decoration was raised and the registered manager informed the meeting what decorations were taking place and what the plans were. There was also a lot of discussion about the recent concerns and the involvement of the local authority. The registered manager was very open in their responses within the minutes of the meeting.

Is the service well-led?

Our findings

There was no evidence that the provider had regular auditing and monitoring processes in place to check the quality and safety of the service provided. Although documents were available to show that some auditing should have been undertaken, these were not carried out regularly as scheduled. A cleaning schedule was in place for the cleaning staff to record daily, weekly and monthly tasks. These were not always completed. The daily cleaning schedule was generally completed but occasionally not. The monthly schedule had only been documented once and a number of tasks were not completed that month. We saw that a weekly audit by senior staff to monitor the cleaning and make sure the schedules were completed had not been undertaken. These processes were in place to ensure the cleanliness and safety of all areas within the home and would assure people and their relatives of this if undertaken correctly.

Medicine audits should have been carried out on a regular basis by a member of the management team. However these had not been completed consistently, for example; the weekly medicines audit had been completed for five out of 23 weeks and the monthly registered manager's audit had been completed for two out of 11 months. These processes if completed as recorded would give people assurance that their medicines would be administered safely.

We found no other regular auditing of recording systems and documents or processes to reassure people and their relatives of the quality and safety of the services provided within the home. Audits such as individual risk assessments and fire evacuation planning and assessment would have highlighted the issues we found.

The provider had not asked the views of others regarding the provision of the service in order to make improvements to the quality and development of the service. No surveys had been undertaken to gauge the views of people using the service or their relatives. This would give the opportunity for everyone to have their say. Although resident and relatives meetings had been held, not everyone wished to attend open forums or give their views openly. A staff survey had not been undertaken by the provider to give staff the opportunity to have their say about the quality of the service provided or the support and development opportunities available to them.

This is a breach of Regulation 17 (1)(2)(a)(b)(e)(f) of the Health and Social Care Act 2008 (Regulations) 2014. Good Governance.

The registered manager knew people well and could speak with knowledge about their needs and the things they liked and disliked. Relatives knew the registered manager and felt that she was easy to get on with and that they could talk to her. One person's relative told us, "I am very happy with the home, I can't fault it". Another said "I would go to the manager if I had an issue".

The provider's whistleblowing policy did not include how staff could raise a concern outside of the organisation should they have concerns they felt were not being dealt with by the provider. The only contact details were for the registered manager and the provider. This meant that staff did not have the information

readily available to raise concerns outside of the home if they felt they weren't being listened to.

We recommend the provider and registered manager adds contact details of external sources that staff could contact should they need to raise concerns outside of the organisation.

Concerns had been raised about the poor performance of some staff members with the local authority and CQC during 2016. The provider and registered manager had worked closely with the local authority to resolve these issues throughout this time. All people living at the home had been visited by health and social care professionals to reassess their care needs and to find out their views of the home. People's relatives had also been spoken to as part of the review process undertaken by the local authority. Health and social care professionals told us they were confident the provider and registered manager were dealing with the concerns raised and improvements had been made. One health and social care professional said, "The new manager appears competent and is getting things done slowly".

The registered manager received support from the provider when they visited about once per week and was able to contact them if they needed to. However, there had been a lot of issues to deal with since the registered manager came into post in April 2016 and little extra support had been given to assist with managing these situations. We spoke to the provider about this who assured us they would put a plan in place to offer more peer support to the manager and link them in with a network of other managers. The provider contacted us following the inspection to outline the plan that was in progress.

Staff generally spoke positively about the registered manager. All the staff we spoke to said the registered manager had made a difference since coming into post earlier in the year. They said staff morale had been low but had now picked up considerably. Staff said some of the changes had been difficult for some staff but the benefits to the home were noticeable. They said the registered manager was supportive and listened to their views and clearly put the interests of people first. One member of staff said, "The manager has made many improvements, the paperwork is more professional now and she is making the care plans much better". Another member of staff told us, "It's nice having a manager you feel you can talk to. There have been lots of changes, paperwork and things, it's much better".

The registered manager had staff meetings to keep staff up to date and give the opportunity to raise concerns or make suggestions. The registered manager had met with staff twice since they came in to post and told us they intended to meet more regularly now that other priorities had been dealt with. Night staff told us the manager had made sure they met with them regularly to offer support. One staff member said, "The manager has made herself known, she makes a point of staying late sometimes to see us". Another staff member told us, "Yes they are having staff meetings now, they keep us informed about the changes and what they are doing, if we can't go the meeting minutes are in a folder so we can read them when we are next in".

The relatives we spoke with told us about the resident and relatives meetings. Two sets of relatives felt the recent meetings had not worked well. They felt there should be a solely relatives meeting that could be held in the dining room where the relatives could talk freely without upsetting people who may not understand the context of discussion. One relative expressed they wouldn't attend if the organisation of the meeting remained the same in the future. We spoke to the provider and registered manager about this who were aware of the thoughts of some relatives as this had been raised at the meeting. They felt it was important people were able to attend if they wished however could understand the concerns raised. The provider and registered manager said they would discuss this with relatives and come to an agreement.

The registered manager had a positive attitude and was clearly working hard to improve the service

provided. They told us there had been a lot of issues to deal with since their commencement in post, however, they felt the service had improved and was continuing to improve. Many staffing issues had been dealt with which meant they had been short staffed for a time and had recruited new staff. One member of staff told us, "The manager is working really hard to improve things". A health and social care professional said, "The new manager appears competent and seems to be managing to make progress".

The provider had clearly displayed the CQC rating from their previous inspection on 12 and 14 October 2015 on the notice board in the main hallway.

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 and registered manager failed to assess people's preferences and interests in order to plan and deliver meaningful activity opportunities to people.
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Regulation 12 (1)(2)(a)(b)(d) The provider and registered manager failed to assess and mitigate individual risks and environmental and fire risks.
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance 17 (1)(2)(a)(b)(e)(f) The provider failed to undertake the regular monitoring and auditing of services provided to check quality and safety or to seek feedback in order to carry out improvements to the service.
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Regulation 18(1) The provider failed to provide and deploy sufficient staffing to meet the needs of people living in the home.

