The Oasis Care Home Limited

The Oasis

Inspection report

90-92 Plymstock Road
Plymouth
Devon
PL9 7PJ

Tel: 01752403256

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service effective?	**Requires Improvement**
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 the 10 and 11 April 2018 and was unannounced. This is the first inspection for this service since the provider's registration changed on the 27 February 2017. Evidence for this inspection provided by the registered manager and provider at times, predated this registration date.

Since February 2017, we have received two whistle blower concerns and three complaints. These raised concerns about the equipment being used in the service, one concern about end of life care, concerns about how staff were recording when they administered medicines and the training of new staff. A whistle blower also raised a concern about the staffing, language ability of staff, medicines being given to people without their consent and alarm mats being in use that are causing people to fall as they slipped under foot when they stood on them. These were raised with the provider who responded. However, we also checked these concerns on this inspection. We found concerns in some areas which are summarised below.

The Oasis is registered for 35 older people who may be living with dementia. On the days we were at the service, 31 people were living there. 19 people were living with dementia or noted to have a level of "confusion" and/or short term memory loss. Staff did not offer nursing care; nursing care is provided by the community nursing team.

The Oasis is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

A registered manager was employed to oversee the running of the service. 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. One of the providers also managed aspects of the service. A deputy manager oversaw much of the administration and shift leads managed the day to day running of the shift, speaking to GPs, medicine administration and organising staff. Different staff had lead roles such as in end of life care and infection control.

The governance framework did not ensure responsibilities among staff were clear. Throughout this inspection, we found staff roles were poorly defined. Records about the same issue were held by different staff in different parts of the service. The registered manager and registered providers deferred accountability to each other rather than remaining accountable or at least knowledgeable about how that area of running the service was being maintained.

The registered manager and provider failed to have effective quality assurance systems that ensured all areas of the service were safe and of the quality expected. For example, during the inspection we identified a number of areas that were not being monitored. This included infection control; ensuring people had the required risk assessments in place; staff were suitably trained, supported and informed and people's records reflected their choice. Where audits were completed, these did not evidence what action had been taken to resolve the issues identified.

People were not always protected by safe infection control and food handling practices. We witnessed poor infection control practices. All staff had not been appropriately trained to keep people safe. The laundry was not being managed safely. Chemicals were not being handled in line with legislation. We advised Environmental Health of these concerns.

People were not always ensured any risks would be identified or addressed. People at risk of choking, high or low blood sugar (diabetes), and/or due to the use of blood thinning drugs did not have their risks assessed. People's care plans only contained minimal information and were the same for each person. They lacked personalised details about how the person required their care to be delivered. Examples of missing essential information included how staff supported people living with dementia, diabetes and having a catheter in situ.

People and their families gave positive feedback about the quality of the food and people at risk were identified, assessed and had their needs met. People told us they were no longer being asked what they want to eat and the menu showed one choice of meal. People confirmed they could ask for other choices which would be given them. The provider, when told of this advised, everyone should be being asked what they wanted to eat before each meal. They acted to reinstate this.

People had activities provided but we observed times during the inspection when people sat in the lounge, mainly asleep, for large parts of their day with little or no stimulation from staff.

People had their faith and cultural needs met. People's end of life needs were planned for and the service had achieved accreditation from the local hospice.

The management of medicines was not always in line with current guidance. For example, we found many gaps in the medicine administration records (MARs); handwritten ones did not hold a second staff signature to ensure accuracy. Codes that told us why a person had not been given their medicine were not consistently used. People said they received their medicine as required.

The Mental Capacity Act 2005 (MCA) was not fully understood by staff we spoke with. People received medicines covertly. That is, without their knowledge and consent. The service was not demonstrating they had recorded the person's capacity and this was a best interests decision. This was the same in respect of the use of alarm mats reported to us by the whistle-blower. We discussed consent with staff and observed people receiving support that allowed them time to choose.

People were not ensured to be safe in the event of a fire. We spoke with the fire service who attended during the inspection. This was due to gaps in training staff (at night), the standard of the Personal Emergency Evacuation Plans (PEEPs) and the laundry. The fire service have written to the provider about these issues, emergency lighting and ensuring an upstairs exit, that could pose a fall from height, as the door will release when the fire alarm sounds. The provider has provided further information following the inspection that all staff training in respect of fire safety has now taken place.

All staff were not suitably trained, supervised or checked as competent to carry out their role effectively.

Staff were recruited safely. Staff understood how to recognised abuse and what steps to take to keep people safe. Staff would report any concerns to senior staff and felt action would always be taken. Staffing levels on the day of the inspection were appropriate to people's assessed needs. All staff we spoke with said there were enough staff on duty at all times to meet the needs of people.

People said their health needs were met and they could see a range of health professionals as needed. People told us the staff were kind, caring and responsive to their needs. People said they felt respected and treated with dignity at all times. Some people said the training of some staff could be improved so all staff were as skilled.

People, families, professionals and staff had opportunities to speak about any complaints, worries and ideas about how the service was being run. The registered manager and provider told us they were looking to improve this.

We found three breaches of Regulations. Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

We also made a recommendation that the provider uses reputable sources to ensure people living with dementia receive appropriate levels of interaction and stimulation.

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. People were not kept safe due to poor infection control practices. People's risks were not always assessed and mitigated. People received their medicines as prescribed but the management of medicines was not always safe. Staff knew how keep people safe from abuse. Staffing levels were appropriate to people's needs and staff were recruited safely.	**Requires Improvement**
Is the service effective? The service was not always effective. Staff were not always trained and supported to carry out their role effectively. The records of how people's right to consent was sought and assured were not complete. People were positive about the food and people who needed support had these needs met. Systems to ensure people had choice were not working effectively. The provider ensured this was in place going forward. People had their health needs met. People and families said they could see the GP or other health professionals as needed.	**Requires Improvement**
Is the service caring? The service was caring. People were treated with respect and have had their dignity protected.	**Good**

People were supported by staff who were kind, considerate and made sure people's emotional welfare needs were met.

People and family were given the opportunity to comment on the care received.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People were happy with their care but their records did not provide staff with the personalised details needed to ensure their care was as they desired.

Activities were provided but people had spans of time when there was no interaction with staff and staff were not available to respond to their needs.

A complaints policy was available for people. People felt they could raise concerns and these would be reviewed.

People's end of life needs were met. Staff were trained and understood how to meet people's needs at their end of life.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Robust quality assurances processes were not active to ensure the quality of the service.

The registered manager and provider were not demonstrating how they learnt from events to improve the service.

Responsibilities among senior management staff were not clearly defined which meant information was not readily available when required.

People, families, staff and professionals had the opportunity to feedback and makes suggestions about the service.

Staff worked with key professionals in respect of people's care as needed.

CareQuality Commission

The Oasis

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 the 10 and 11 April 2018 and was unannounced. The inspection was completed by two inspectors.

Prior to the inspection, we ensured we read all information we held on the service including information we had received and enquiries we had received. Enquiries tell us about issues within the service that registered people have to tell us about.

We used information the provider sent us in the Provider Information Return (PIR). This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

During the inspection we spoke with 10 people and reviewed the records of five people in detail. We spoke with and/or checked that these people were receiving good care. We also spoke with three visitors/relatives and gave questionnaires that could be filled in by them as well. We received six questionnaires back.

We spoke with 10 staff and checked the personnel records of three these. We reviewed the training of all staff. We spoke with the providers, registered manager and deputy manager. We read records identified by the registered manager and provider on how they reviewed the quality of the service. We also observed how staff interacted with people in the lounge and at lunch. We completed SOFIs (A SOFI is an observational tool to record the care of people who cannot otherwise communicate with us.)

We spoke with one community nurse and one continence nurse during the inspection. We also spoke with the fire service (who attended the service while we were there) and environmental health about some concerns we had that we needed their guidance on. We spoke with the local authority following the inspection to seek their feedback.

Requires Improvement

Is the service safe?

Our findings

The service was not always safe.

People were not always protected by safe infection control and food handling practices. Staff were observed moving from tasks in the home and then into the kitchen. For example, we observed bins being emptied from a toilet without an apron on and then this staff member completing tasks in the kitchen (sometimes with but not always a plastic apron over the top of the clothes that had been used to carry out cleaning tasks). Clean laundry was being folded wearing the same apron that had been worn to handle the dirty laundry and red bags containing contaminated laundry. Several times during the inspection we advised staff to not walk around the home wearing gloves that had been used for cleaning, care or food preparation.

The laundry posed a risk of cross contamination and service users coming into contact with unsecured chemicals. The laundry was very small and the room cluttered. There would be no possibility of being able to keep the small area of floor clean or ensure it was mopped often. There were stacks of dirty laundry observed on both days of the inspection. Chemicals were stored on the floor. The door was not locked and did not close on its own or in the event of a fire alarm. Red soluble bags containing contaminated laundry were being placed directly on the floor in the laundry. Other washing stored in a red (contaminated) and blue laundry fabric bags (should be none infected clothes) were being left in one of the showers on the shower chair used by people to have a shower.

Staff advised they put the washing through as quickly as they could but had to wait due to the lack of facilities and high level of incontinence. We advised the registered manager that we were concerned about the laundry on the second day of the inspection. A laundry bag attached to a frame was brought. This bag, which was in a poor state of repair, did not have sufficient capacity to take the large amount of laundry waiting to be washed. The bags containing contaminated washing were therefore leaning against the walls which posed further risks of contamination.

This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We advised the environmental health service of our concerns in respect of infection control and food safety. We advised the fire service of our concerns in respect of the laundry and they gave their own advice. That is, "The responsible person must ensure that fire resisting doors are effectively self-closing and in good repair".

Staff were provided with plenty of personal protection equipment (PPE). Sharps, contaminated and commercial waste were appropriately disposed of. We found the external clinical waste bin was unlocked which the provider told us they would address with the supplier as no lock had been provided. Following the inspection, the provider has sent us their detailed plan (updated January 2017) on housekeeping procedures to be completed.

People were not always assured any risks would be identified or addressed. People at risk of choking, high or low blood sugar (diabetes)and/or prescribed blood thinning drugs, did not have their risks assessed. People's care plans contained minimal information and were the same for each person. For example, the care plans for people with diabetes stated "blood sugars should be monitored by a competent person" and, "if results are high or low from normal range GP is to be informed." There was no record of what 'high' and 'low' meant for that individual person. Also, staff were not provided with information on how to recognise a hypo (low) or hyper (high) glycaemic incident. This meant staff did not have the required information available to keep people safe.

Staff told us they were taking people's blood sugar readings. We asked the registered manager how staff had been trained and assessed as competent, and whether this had included maintaining the electronic blood sugar reader. We were told training had been provided at some point by the community nurses but we could not establish which staff had received it and when. It was not documented on the training matrix. This meant it could not be guaranteed people's blood sugars were being taken accurately.

One person's records stated they had been seen to be choking on their food in January 2018, as "they had put too much food" in their mouth. Staff used first aid on the person moving from a slap on the back to using the Heimlich manoeuvre, or abdominal thrusts. This person's record included no other details about whether medical support or advice was sought or if that person had then been assessed as a choking risk. When we raised this with one of the visiting nurses, they told us this person tended to "shovel" food in. We asked staff to check if a call to a health professional had taken place in response to the choking incident, and if a referral had been made for an assessment of their risk of choking. We were advised by staff whom we asked to review their records that none of these events had taken place.

Between October 2017 and March 2018 there were 25 documented falls for one person. They moved into the service on the 3 October 2017. Their falls risk assessments, completed on the 14 February 2018 and 20 March 2018, noted they were high risk of falls. However, all their risk factors had not been considered as part of these assessments. Falls out of bed had not been reviewed to see if their type of bed needed assessing and when we visited their room, an alarm mat that was very slippery under foot was in use. The registered manager advised they would discuss this person with their GP so their needs could be reviewed.

There was no dedicated evacuation equipment because the provider believed that the fire and rescue service carried this equipment. There was a "grab bag" staff were to take with them but it contained an out of date list of people living at the service. Personal Emergency Evacuation Plans (PEEPs) were in place but the description of people's needs was very vague and would not give staff and the emergency service enough detail of people's ability in the event of an emergency. The fire service has advised, "The responsible person must ensure that adequate provision has been made for the evacuation of all people in an emergency. This includes people who are especially at risk such as people who may be asleep, young people (i.e. those under 18) and people with temporary or permanent disabilities".

The fire service found all escape routes were not adequately lit as the outside had no emergency lights. Also, suitable measures were not in place to ensure people would not suffer a fall from the upper fire exit that led onto the external stairs. This door would release when the alarm sounded but there were no systems in place, such as a risk assessment and system to release the door in managed way, to ensure people who could not manage their own risk did not inadvertently exit this area.

This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider has provided further information following the inspection that all staff training in respect of fire safety has now taken place. Also, the provider has advised, general information about high or low blood sugar is available to staff.

People said they received their medicine as required. However, we found the management of medicines was not always in line with current guidance. The service used a monitored dosage system. We found many gaps in people's medicine administration records (MAR) which suggested either medicines had not been given or they had been given and not been signed as administered. We also noted that there was lots of hand written MARs with information missing. For example, the quantity of medicine prescribed and, the good practice of two staff signing to ensure accuracy when checking in medicines to the building. Staff were not always recording why people had not had their medicines. This meant that it was difficult to know if the person was offered their medicine, whether they declined or refused it. The punched holes in some MARs had broken and sheets were then loose and could easily be mislaid or lost. One MAR did not have the name of the person who should receive medicine. Another person did not have a completed profile which meant that staff could not retrieve information quickly on allergies, swallowing difficulties, date of birth and doctor, for example.

Covert medicines were administered in a disguised format at the service. Letters from people's doctor were shown to us to say this was fine however, NICE (The National Institute for Health and Care Excellence) guidance and the provider's medicine policy had not been complied to ensure a best interests decision (in line with the Mental Capacity Act 2005) had been recorded before covert medicines were given.

All staff who administered medicines told us they had received medicine training. However, we found errors continued and there was no recorded system evident to show that staff then received further training or that their competency to administer medicines had been assessed further and before any administration then took place.

Staff told us they checked how medicines were being managed by regular audits. We looked at the most recent audit which also, for example, identified omissions in recording on the MAR sheet. There was no management oversight of those findings or action plan as a result of what was found.

The provider's medicine administration policy referred to previous legislation. It referred to different pieces of legislation which include the Care Standards Act 2000. The Care Standards Act 2000 was superseded by The Health and Social Act 2008 which was revised again in 2014. This meant the provider was not working to most current regulations.

This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We observed staff dispensing medicines on three occasions and each time medicines were administered correctly and with care. When medicines were taken the MAR sheet was signed by the staff member as they administered. This meant people had taken all medicines as per the MAR sheet. Medicines were stored safely and those that required refrigeration were monitored to ensure they were kept at the right temperature to remain effective.

Staff understood how to recognise abuse and what steps to take to keep people safe. Staff would report any concerns to senior staff and felt action would always be taken.

Staffing levels on the day of the inspection were appropriate to people's assessed needs. All staff we spoke with said there were enough staff on duty at all times to meet the needs of people. Staff were supported by the providers, registered manager, deputy manager, activities coordinator and maintenance person. Staffing levels were reviewed in respect of numbers and people's needs increasing at times of illness or when people were at the end of their lives. One relative we spoke with said, "I am happy with the number of staff on duty". All the people we spoke with told us they were happy with the number and quality of staff.

We saw that recruitment processes were in place to ensure staff were safe to work with vulnerable people. There was a thorough interview process which included questions to assess staff ability, attitude and understanding about working with vulnerable people, some of whom may be living with dementia. Prospective staff completed an application form, work history, proof of identification and barring service check (DBS). A DBS is a check that is completed to check that the person does not have criminal record which may make staff unsuitable to work in care.

Requires Improvement

Is the service effective?

Our findings

The service was not always effective. The PIR told us staff had completed mandatory training which included Mandatory Training - Fire, Moving and handling, Infection Control, Medication, First Aid, Dementia, End of Life, Safeguarding, MCA and DoLs. Specialist - Continence, Diabetes, Nutrition, Equality and Diversity, Bullying and harassment, Hearing and Sensory Loss, Skin Care, Supervision Skills" and, "Staff are supported to have relevant training and the least qualification held is the Care Certificate." However we found all staff were not suitably trained to carry out their role effectively.

Staff working in the laundry and cleaning had not had infection control training and we observed practice that would place people at risk of cross infection. Staff who delivered care were not being trained in food safety. The staff member who was cooking the main meal on the second day had also not had food safety training. Food hygiene training would ensure they understood the importance of safe food practice.

The Mental Capacity Act 2005 (MCA) was not fully understood by staff we spoke with. Staff told us that they felt they would like more training in MCA and DoLS. MCA and DoLS provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. We looked at the training records for MCA and associated Deprivation of Liberty Standards (DoLS) training and noted that the last training took place in 2016 for five staff. Very few of the staff who delivered care were trained to understand how the MCA and DoLS applied to their role when supporting people who lacked capacity.

People were not always supported by staff who had received supervision and appraisal. Supervisions and appraisals are meetings with management designed to support, motivate and enable the development of good practice for individual staff members. The staff we spoke with said they were supported by the registered manager who always made the time to sit down and listen to them. We spoke with the manager and looked at current records which showed that supervision and appraisal for all staff had not taken place. The manager provided us with a supervision matrix and planned to supervise staff in 2018.

We spoke with the fire service about concerns that not all staff had suitable levels of training in fire safety and evacuation. The fire service advised, "The responsible person must ensure that employees receive appropriate fire safety training so that they are aware of the fire safety provisions and emergency action plan".

This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We advised Environmental Health of the issues in respect of food hygiene and infection control. The provider has provided further information following the inspection that all staff training in respect of fire safety has now taken place

Staff were supported to take advanced certificates in care. The registered manager had attained the Level 7

Award in Strategic Management and deputy manager and duty managers the Leadership Level 5 award in Health and Social Care.

Twenty three people living at the service were identified to us as having a condition that could affect their cognition or were living with dementia. There were certificates and awards displayed at the main entrance for Dementia Friendly City award 2013 and Dementia Quality Mark dated 2015. These were from the service's previous registration. The training matrix showed most staff had completed dementia awareness training however, some had completed this some time ago. The registered manager advised that the training was planned for all staff.

New staff underwent the service's induction and the Care Certificate. The Care Certificate was brought in on 1 April 2015 to standardise the knowledge and skills of all staff new to care.

All the people we spoke with said they were happy with the skills and knowledge of the staff who cared for them well. One person told us, "Staff are very good knowledgeable and have good skills". However, one family member told us the staff training was, "Generally good, but some staff are better than others" and another said, "Some staff are better than others."

We spoke with the registered manager about the need to ensure all people's diverse needs are met. They advised they were reviewing this further. The PIR told us in respect of Equality, Diversity and Human Rights that the service intended to put in place, "Training on Equality and Human Rights to be rolled out to all staff. Some staff have done this as modules in their NVQ training and this will be discussed at handovers, staff meetings and supervisions."

We checked whether the service was working within the principles of the Mental Capacity Act 2005 (MCA) and whether any conditions on authorisations to deprive a person of their liberty were being met. When we spoke with the registered manager about the MCA and Deprivation of Liberty Standards (DoLS) and how the service were ensuring they were meeting the requirements, they verbally were able to tell us how this was being applied. However, the evidence of this was not available to us.

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's records made reference to people's capacity and the need for staff to work in their best interests when this applied. Our records showed five DoLS had been authorised in 2017. The registered manager advised they had applied for DoLS for other people that were awaiting decisions by the local authority designated officer. However, apart from the authorised DoLS, there was no evidence on people's files showing how their capacity had been assessed, who was involved in that decision making process and, what parts of people's lives staff were making best interests decisions on. It did not say what people could still consent to and how staff were to support this. Also, we were told by staff that all authorised DoLS and applications should be contained on people's files. This was not the case for all of the people we reviewed and staff were unable to locate them.

Where DoLS applications were awaiting decisions, all records stated staff were to work in "the least restrictive" way. However, no more detail was given to staff or evidence how this was then reviewed.

Nineteen people had alarm mats in place at the start of the inspection. We were told they were used in place of a call bell for people where there was a fall risk to alert staff the person was on the move. Fourteen of these mats were slippery and moved under foot when stood on. Staff were not ensuring the reason behind using the mat or whether consent was recorded and reviewed. We asked for an audit to be completed so we could better understand how the use of these mats had evolved. This led to some people being identified as no longer requiring the mats, increased checks for others and four people then needing DoLS applied for.

This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We discussed consent with staff and observed people receiving support that allowed them time to choose. Staff demonstrated that they understood the importance of ensuring people consented where possible and how to support people to choose. For example, when supporting people in the lounge or when eating their lunch.

Staff appeared to follow the Accessible Information Standards for people who used the service and had information and communication needs relating to a disability, impairment or sensory loss. Plus, for people who had a condition which affected their ability to communicate. For people who used the service this appeared to work very well and met their needs.

The service ensured that information was accessible to people and their relatives in their preferred manner. For example, via email, letter or text message. Throughout the service consideration has been given to people who use the service who have particular needs for the layout of communal space and associated signage which aid their remaining capacity.

People and their families gave positive feedback about the quality of the food. One family member said, "The standard of the food is excellent" and another, "They seem very well fed. I have often looked into the kitchen and seen home cooked meals."

We observed the menu on the tables (for the previous week as it had not been changed) and the activity list noted one main meal only and no dessert. Our observation at lunchtime on both days showed people could ask for an alternative meal which was provided. People who required staff support had their food in the dining room first; a group of about five who liked to talk to each other had their food a little later. We observed staff supported people to eat and drink in their own time and spoke with them.

People who could speak with us told us they were not asked what they wanted to eat "anymore" but could "book" other meals if they wanted to. For example, one person told us they did not want the fish dish the Friday coming so had asked for a pie and had every confidence this would be what they were served. The same person said, "They used to check but no more". Another person said, "I have seen them give others sandwiches." A further person said, "You get water but you can ask for juice." A different person again told us staff always made sure they had something that would not aggravate a mouth condition they had.

One person, who had been living at the service for about six weeks, told us they had not been yet asked what they liked and disliked to eat or drink. They added, "I came from hospital and did not know what was going on". Another person added, "She knows now because we told her." All those present told us they were not asked to contribute ideas to the menu.

When we spoke with the provider and advised of the above concerns, they were concerned as they understood the opposite was taking place and people should have been asked before each meal what they wanted to eat. They spoke with staff who confirmed people's views. They told us they would put this right straight away.

We found people's records held no detail of what people liked to eat or drink. Allergies were recorded but no other details. This meant staff had no detail available, in respect of what people who could not communicate, would choose to eat if they had been able too. We advised the registered manager this was a concern. They told us staff should be looking at the 'This is me' document but would look at how build this information into people's care plan.

Where there were concerns about people's weight and eating, support was sought from the GP to refer to the right service. The GP gave advice or people were then assessed by the Speech and Language Team or a dietician. Kitchen staff had details of who required their food prepared in a specific way and we were assured this was always provided.

People had their health needs met. People and families said they could see the GP or other health professionals as needed. People had an annual medicines review with their GP and were offered an influenza vaccine each year. People saw an optician, dentist and podiatrist as required. The service was taking part in the "Red Bag pilot scheme" to facilitate safe and timely admission and discharge for the residents to and from hospital. The PIR advises the service "Promotes the identification of frailty and pain using tools e.g. Rookwood Clinical Frailty Scale and Abbey pain Scale to get timely input and support from GPs and to prevent unnecessary hospital admissions".

Good

Is the service caring?

Our findings

Throughout the two days we observed the interactions between staff and people and noted that it was caring and respectful. Two people we spoke with told us that "Staff promote my privacy and dignity". They gave examples by ensuring towels were used to afford privacy and doors were closed when providing personal care. We observed staff respecting people's privacy by knocking on room doors before entering. One person said, "I like the staff, staff are excellent", and another said, "I can have my friends here and staff make it happen". A third person said, "I like the staff, staff are excellent and always helpful and respect my dignity and privacy".

A relative said "I am happy with everything". Another relative also told us, "They are kind; they dance with him and respond to his smiles" and described the atmosphere as, "Very homely". A third described the staff as, "Kind, helpful and caring."

People who could communicate with us felt they had control of their care and staff listened to them and made sure they could lead the life they wanted to. Those who were able to maintained contacts with their community and attended groups and places of worship. One person was involved in local community groups and told us how staff supported them to make arrangements as necessary. For example, providing a packed lunch or keeping a meal for them that they ate when they returned. Another person said, "I go to bed and get up when I want to".

We observed during the SOFI that one person's relative left and staff kept an eye on them and checked they were alright and provided company for them for a little while. Other people living with dementia who had the desire to walk were gently walked with, had their hand held and were guided back to their chair, or were taken to be with staff in the garden.

A relative told us, "My relative hasn't been here long but I am very pleased with the service; they have settled really well here".

Staff spoke positively about working at the service. One staff member said, "I like it here and would let my nan live here".

A Keyworker system was in place that linked a staff member with people, and their relative where appropriate. Staff told us this had recently been reintroduced and should be more effective in making sure people's needs are met.

The PIR stated, "Our ethos and values is to care for others the way we would like to be cared for. Residents are empowered to do and lead activities which give them a sense of purpose" and, "We have been able, with the support of family, communicate with a resident whose first language is not English. We have also used flashcards and pictures to communicate."

The service held "Conversation Clubs" with people on a regular basis. These were hosted by the activity coordinator and were a time for people to talk about any aspect of their care and how the service was running at that time. The last one, held in March 2018, looked at aspects of the service and asked whether the service was safe, effective, caring, responsive and well-led. An action plan was developed from this and people told what was happening with the issues they raised. One person told us, "I really appreciate this time."

Requires Improvement

Is the service responsive?

Our findings

The service was not always responsive. Staff could describe people's care however, people's care plans lacked the details of how their care was to be delivered by staff in a personalised manner. Where people had specific conditions, the wording for each person was the same. This included the role of staff and the goals for that person. For example, there was no information about how people living with dementia or diabetes were affected by their particular condition or how staff could support them as individuals.

Catheter care for one person lacked the detail of how staff were to look after this person; it did not cover personal hygiene, fluid intake and what to look out for if the catheter needed the attention of the community nurse. This meant staff did not have the essential details available to them to care for this person and how to recognise when something was not right.

The PIR states, people's "Life history and "It's all about me" is documented during admission so that we know the preferences and choices of the residents. The resident, family and carers are involved in this process". The records we reviewed did not all hold this document and where they were present; this information had not been transferred into the person's care plan. This meant staff did not have the required details to refer to in order to ensure they were delivering care as that person desired.

This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

On the first day of the inspection, we observed in the morning when we arrived that 16 people were sitting in the main lounge; they were all asleep. We observed over the next two hours that little happened for people. Staff were not visible; people were not approached who needed staff support to go to the toilet. People did not have the cognitive ability to call for staff support; there was no evidence people had call bells. Later in the morning, the activity co-ordinator provided a knitting activity in a separate room that was enjoyed by those who took part. People in the main lounge however continued to be left without any staff intervention or support. The TV was on silent at one end of the room and music was playing. Their main interaction was when drinks or meals were served.

On the second day of the inspection we discussed our concerns with the registered manager about the lack of contact with staff for people in the lounge. We also raised a concern that the music in this room appeared to be 'the activity' for people having been referred to as such by staff. On the second day of the inspection, the activity coordinator was carrying out catering duties which meant they were not available to support people to remain active. Both inspectors completed a SOFI in the afternoon on the second day. This demonstrated an improvement on the previous day, but there were still periods of time where people were snoozing, watching and having little interaction with staff. This was despite staff being present who were completing paperwork and/or sat 'watching' people.

A relative told us, "I feel [those living with dementia] need more stimuli – interaction and simple exercises.

Fun things which they can get involved with. This is the area that concerns me most."

We recommend the provider uses reputable sources to ensure people living with dementia receive appropriate levels of interaction and stimulation.

The staff we spoke with knew the importance of respecting people's diverse needs and choices. They gave us examples of how they respected peoples' diverse needs, including how people would be supported to continue with the faith of their choosing. People with a higher levels of cognition told us how their lifestyle experienced living at the service matched their expectations and preferences. They also told us this satisfied their social, cultural, religious and recreational interests and needs. People told us there was "plenty to do".

The registered manager understood about the accessible information standards and told us they were active in looking at how this could be put in place for people as needed.

No one at the service was currently at their end of life. The service had End of Life Champions allocated who are specially trained staff who ensured that residents have advanced care plans in place where possible. The PIR advised us coffee mornings were held with people and their families to discuss advanced care plans for End of Life. The home had achieved "Six Steps Accreditation" with the local Hospice to enable the service to be proactive in identifying when the resident is at End of Life and to ensure that they have access to support and dignity. The majority of people had Treatment and Escalation plans in place which had been discussed with them, their family or representative to ensure their wishes were detailed in respect of intervention by medical professionals at their end of life. These were shared with the ambulance and other health professionals as required. The PIR also said, "A person that passed away in hospital had the priest come in once a week to offer communion. When they were admitted to hospital, and we were informed that she was at End of Life, we made sure we contacted the priest who went immediately to hospital to administer Communion before they passed away".

A family member wrote to the service in March 2017, "You cared for my mother until her passing. Thank you for all you did to make her comfortable during her time with you. She was always so happy to be with people she knew and she had a lovely room. Whenever I visited and they were always unannounced the staff were very helpful happy and friendly".

The service had a complaints policy available for people and their families to read. Complaints and concerns had been investigated and discussed with those involved. People living at the service were invited to Conversation Club every week; this was an opportunity to discuss ideas and themes of their choice but could also be used to talk about the service and any issues they had. We received positive views from people living at the service about how the registered manager encouraged them to make suggestions about how the service may be improved. They told us that there was an open culture within the service that enabled them to feel confident in making suggestions and for making complaints without fear of victimisation.

Requires Improvement

Is the service well-led?

Our findings

This is the first inspection since the provider changed to a Limited Company. The service has continued to be run by the same registered manager and nominated individual. 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. A nominated individual (NI) is someone nominated to respond on the behalf of the provider. In this case, the NI is one of the two registered company directors.

The registered manager and provider failed to have effective quality assurance systems that ensured all areas of the service were safe and of the quality expected. For example, during the inspection we identified a number of areas of the service that were not being fully monitored. This included infection control; ensuring people had the required risk assessments in place; staff were suitably trained, supported and informed and people's records reflected their choice. Where audits were completed, these did not evidence what action had been taken to resolve the issues identified. Examples were the fire risk assessment and the medicine audit. There was then no evidence that there were systems in place that analysed themes identified as part of quality audit to help drive improvements at the service.

On this inspection we found there was a poor understanding between the registered manager, provider and other senior staff as to who had which role and responsibility. Different senior staff would defer to other staff in the 'senior management team' during the inspection, when we were seeking a piece of information or were unclear about who was responsible for certain decisions being made. For example, the registered manager deferred to the provider (second director) in respect of all costs including training. The NI deferred to the other director or the registered manager when we spoke about this and other issues.

We also found systems in how information was held were distributed among senior staff without anyone ensuring the information was readily available if required. For example, it took seven days to be assured the passenger lift had been maintained. Some senior staff also held different information in respect of records detailing people's care and when we said we were concerned about something we had read; we were directed to another record held by another staff member that told us what the bigger picture was. For example, when we were looking at how the home ensured they were monitoring falls for the individual and as a service, we were shown three different records held by different staff before we could be assured this was being monitored and mitigated. The different staff were not then aware of where the other information was.

There were no effective systems in place to ensure people and staff were protected by the use of chemicals. This meant the requirements in respect of the Control off Substances Hazardous to Health Regulations 2002 (COSHH) were not being adhered to.

The provider's infection control policy (reviewed each year) did not address the areas required by the Department of Health Guidance. For example, catheter care and taking blood sugars safely was not covered.

When we spoke with the registered manager they were unaware of this guidance and that provided by the Health and Safety Executive to ensure they met their legal requirements in respect of people and staff. An audit of infection control completed monthly did not identify the laundry as an issue, as we had, or that all staff had not had the required training. The staff member completing the audit and acting as infection control lead had not been trained to understand the guidance and how to complete the audit.

This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We spoke with the registered manager and Nominated Individual (NI) about the issues we had identified with Infection Control and staff training. We also told them about the issues with the laundry not being easily accessible and COSHH systems not being in place. We were advised these concerns would be looked at. The provider advised they had planning applications in process to develop a new laundry. This had been rejected and needed more time. We advised there was a need to improve the laundry in the meantime in order to ensure people are safe.

The PIR states, the provider aims to "Strengthen and improve on quality assurance and audits. Introduce quarterly meetings and surveys with family members to create a platform to discuss compliments, concerns and complaints". The provider's website stated, "Our ethos is simple…'To care for others as we would wish to be cared for ourselves'."

People, families, staff and professionals had the opportunity to feedback and makes suggestions about improvements at the service. This included the use of questionnaires along with conversation clubs. The PIR states, "Family Forum to be set up and running. Continue to include family and residents in care planning and support within the home. Ongoing training for staff. Staff to continue to have quality time with residents and to record outcomes." In July 2017, in response to a complaint, the provider's put in place times families could come and talk with them. The families who took up this opportunity were positive in their feedback.

We received a mixed view from people and families when asked how often they saw the registered manager and providers. When we asked "Who was in charge?" in our questionnaires, three left this part blank and two named a duty manager (senior care staff). One questionnaire identified the registered manager as being in charge. We observed both to be around the home and easily relating to people and families at the service. All the staff we spoke with said that they were happy with the support and informal supervision given to them by the manager. We spoke with staff over the two days and they told us they were confident that the registered manager would listen and act on any concerns they had. The staff told us that they were supported well by the registered manager and providers.

Records showed the service related to other health professionals and services as required.

The registered manager and provider had systems in place to ensure the building and equipment were maintained. The utilities were checked regularly to ensure they were safe.

The registered manager knew how to notify the Care Quality Commission (CQC) of any significant events which occurred in line with their legal obligations. The registered manager and provider also understood their responsibilities in respect of the Duty of Candour. The duty of candour is a legal obligation to act in an open and transparent way in relation to care and treatment.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Regulation 18(1)(2)(a) All staff were not receiving appropriate training, supervision and appraisal necessary to carry out their duties.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Regulation 12(1)(2)(a)(b)(d)(h) Care and Treatment was not always provided in a safe way People's risks were not always assessed and when a risk of choking arose action was not taken to mitigate this risk. The laundry was not ensured to be used in a safe way Infection control measures were not fully in place.

The enforcement action we took:

We served a warning notice in respect of this breach. A warning notice tells providers what they need to put right and by when. This provider has until the 3 August 2018 to address the concerns and put them right. We will return to check this is the case.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Regulation 17(1)(2)(a)(b)(c) Systems and processes were not always established and operated effectively. Quality assurance processes has not been established and maintained to ensure the service was meeting the regulations. Risks were not always being assessed, monitor and mitigated. Records were not always accurate, complete and contemporaneous.

The enforcement action we took:

We served a warning notice in respect of this breach. A warning notice tells providers what they need to put right and by when. This provider has until the 3 August 2018 to address the concerns and put them right. We will return to check this is the case.