Bel-Air Care Limited

Oakleigh Care Home

Inspection report

Oakleigh Road
Clayton
Bradford
West Yorkshire
BD14 6NP
Tel: 01274 880330

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Ratings

Overall rating for this service	Inadequate
Is the service safe?	Inadequate
Is the service effective?	Requires Improvement
Is the service caring?	Requires Improvement
Is the service responsive?	Requires Improvement
Is the service well-led?	Inadequate

Overall summary

We inspected the service on 2 March 2015. The inspection was unannounced.

Oakleigh Care Home is registered to provide personal care to a maximum of 31 people. Most people who use the service are older people and people living with dementia. Accommodation is provided in single and shared rooms. The service is situated in the village of Clayton on the outskirts of Bradford. On the day of our visit ten people lived at the service and only the rooms on the ground floor were in use.

When we last inspected the service on 17 June 2014 we found legal requirements had been breached in relation to; the care and welfare of people who use services, meeting nutritional needs, staffing and assessing and monitoring the quality of service. We asked the provider to make improvements and they wrote to us to say they would take action to ensure they met legal requirements in these areas by the end of September 2014. During this inspection we checked these improvements had been made and sustained.

Summary of findings

The provider had failed to make the necessary improvements to ensure they met legal requirements in relation assessing and monitoring the quality of service. The systems in place to ensure the delivery of high quality care were inadequate. We found a number of concerns which had not been identified or addressed by the provider or registered manager prior to our visit. This showed an absence of robust quality assurance systems. Where issues were identified we found timely action was not always taken to address them. Risks to people's health, safety and welfare were not appropriately reported, managed and analysed. Appropriate action was not always taken in response to incidents and accidents to reduce risks and protect people from harm.

The service has a registered manager. A registered manager is a person who has registered with the Care Quality Commission (the 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. The manager was also the registered manager for another of the provider's services. We found that this meant they were unable to fully dedicate their time to ensure the consistent and effective management of Oakleigh Care Home and the leadership of staff.

The provider had failed to make the necessary improvements to ensure they met legal requirements in relation the care and welfare of people who use services. Risks to individuals had not been fully assessed and were not being appropriately managed to ensure people's safety. Where care plans and strategies were in place to manage known risks, these were not always being followed by staff to ensure people were kept safe. Care was not planned and delivered in a way which met people's needs or ensured their welfare and safety. The provider did not ensure that the care provided was responsive to changes in people's needs.

We found the staff culture was focused on routines, rather than delivering person centred care. Although we saw some positive interactions between staff and people who used the service, people were not consistently treated with dignity and respect. There were occasions where staff did not provide people with appropriate support and interaction and some practices showed a lack of respect for people using the service. There was a lack of meaningful occupation for people and most staff interactions were centred on care tasks.

We found the service was not safe. The provider and registered manager were not taking appropriate steps to ensure people were protected from the risk of abuse. People were not always protected against the risks associated with medicines because there were not effective arrangements in place to manage medicines safely.

People who used the service were put at risk because good standards of hygiene and cleanliness were not being maintained and staff demonstrated some poor infection control practices. The provider was also not appropriately protecting people from the risks associated with unsafe or unsuitable premises.

Staff did not receive sufficient training and support to ensure they provided people with safe and effective care. We saw evidence that this directly impacted upon people through our observations of some inappropriate and unsafe staff practices. Care staff were knowledgeable about people. However, what they knew about people was not always reflected in people's care records or in how they delivered care and support to people.

We found the provider had made improvements to ensure people consumed sufficient quantities of food and drink. People's weights were stable and feedback was that the food was "ok" and "passable".

The provider had made improvements in relation to staffing arrangements. The number of care staff on duty during the day had been increased. We found this meant that there were now sufficient numbers of staff to meet the needs of the people who used the service. Recruitment procedures were in place to ensure the staff employed were suitable for the role.

Overall people told us they were well cared for and liked living at the service. However, people told us and the records showed that they were not being consistently involved in planning their care.

Summary of findings

People were supported to access a range of healthcare professionals to help ensure their general health needs were met. Feedback from visiting health professionals was that staff were helpful and quick to alert them of any issues people may have had.

There were mechanisms in place to obtain people's feedback such as resident's meetings and surveys. We found complaints were investigated and responded to and lessons learned were fed back to care staff to ensure similar issues did not occur again.

We found evidence that the Commission was not being notified of some safeguarding incidents which had occurred at the service. We wrote to the provider and the registered manager and reminded them of their duty to ensure they notified the Commission of certain incidents, such as safeguarding incidents. We explained that if we found evidence they had failed to notify the Commission of these incidents in the future this could result in enforcement action being taken against them.

Systems were in place to monitor and manage situations where people's freedom may have been restricted in order to keep them safe. However, care staff would have benefitted from additional training on the Deprivation of Liberty Safeguards (DoLS) and the Mental Capacity Act 2005 (MCA) to ensure they were fully aware of their duties in protecting the rights of people with limited mental capacity.

We identified eight breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the provider to take in relation to this at the back of the full version of the report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe. Risks were not being appropriately managed and care was not planned and delivered in a way which ensured the welfare and safety of people. The provider and registered manager were not taking appropriate steps to ensure people were protected from the risk of abuse.

People were not always protected against the risks associated with medicines because there were not appropriate arrangements in place to manage medicines safely.

People who used the service were put at risk because good standards of hygiene and cleanliness were not being maintained and staff demonstrated some poor infection control practices. The provider was also not appropriately protecting people from the risks associated with unsafe or unsuitable premises.

The provider had increased the number of care staff on duty during the day. We found this meant that there were now sufficient numbers of staff to meet the needs of the people who used the service. Recruitment procedures were in place to ensure the staff employed were suitable for the role.

Is the service effective?

Requires Improvement

The service was not always effective. Staff did not receive sufficient training and support to ensure they could provide people with safe and effective care. We saw evidence that this directly impacted upon people through our observations of some inappropriate and unsafe staff practices.

The registered manager had a good working knowledge of the legal requirement relating to the Deprivation of Liberty Safeguards (DoLS) and Mental Capacity Act and was able to demonstrate they were working within the law. However, care staff's awareness of these areas was lacking, which meant the correct steps were not followed to assist people with limited capacity to make decisions.

Improvements had been made to ensure people consumed sufficient quantities of food and drink.

People were supported to access a range of healthcare professionals to help ensure their general health needs were met. Feedback from visiting health professionals was that staff were helpful and quick to alert them of any issues people may have had.

Summary of findings

Is the service caring?

Requires Improvement 

The service was not always caring. Although we saw some positive interactions between staff and people who used the service, people were not consistently treated with dignity and respect. There were occasions where staff did not provide people with appropriate support and interaction and some practices showed a lack of respect for people using the service.

Overall people told us they were well cared for and liked living at the service. Care records had been written and reviewed by staff. However, people told us and the records showed that they were not being consistently involved in planning their care.

Care staff were knowledgeable about people. However the information they knew was not always reflected in people's care records and how they delivered care and support to people.

Is the service responsive?

Requires Improvement 

The service was not always responsive. People's care needs had not been always been adequately assessed and appropriate care was not always delivered. The service did not ensure that the care provided was responsive to changes in people's needs.

We found the staff culture was focused on routines, rather than delivering person centred care. There was a lack of meaningful occupation for people and most staff interactions were centred on care tasks. People told us they would like to do more activities outside of the home.

There were mechanisms in place to obtain people's feedback such as resident's meetings and surveys. We found complaints were investigated and responded to and lessons learned were fed back to care staff to ensure reflective practice and that similar issues did not occur again.

Is the service well-led?

Inadequate 

The service was not well led. We found inadequate systems to ensure the delivery of high quality care. We found a number of concerns which had not been identified or addressed by the provider or registered manager prior to our visit. This showed an absence of robust quality assurance systems. Where issues were identified we found timely action was not always taken to address them.

Risks to people's health, safety and welfare were not appropriately reported, managed and analysed. Appropriate action was not always taken in response to incidents and accidents to reduce risks and protect people from harm. Appropriate referrals to other agencies and the Commission were not always being made.

The manager was also registered manager for another of the provider's services. This meant they were unable to fully dedicate their time to ensure the consistent and effective management of this service and the leadership of staff.

Oakleigh Care 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.

This inspection took place on 2 March 2015 and was unannounced. The inspection team consisted of three inspectors.

Before the inspection, we reviewed the information we held about the provider. We also spoke with the local authority commissioning team and local authority safeguarding team to ask them for their views on the service and if they had any concerns.

During the inspection we used a number of different methods to help us understand the experiences of people who used the service. We spent time observing care and support being delivered. We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not express their views to us.

We spoke with seven people who used the service and two visitors. We spoke with two members of care staff, the deputy manager, the cook and the registered manager. We also spoke with two visiting healthcare professionals.

We looked at six people's care records and medicines administration records (MAR). We also reviewed other documentation relating to the management of the service such as training records, audits and policies and procedures.

After the inspection we shared our concerns about what we had found during our inspection with relevant authorities which included; local authority commissioners, the adult safeguarding team, infection prevention team and food safety team.

Inadequate

Is the service safe?

Our findings

During our last inspection we found care and treatment was not always planned and delivered in a way that ensured the safety and welfare of people. During this inspection we found appropriate improvements had not been made. Known risks were not being appropriately managed and care was not planned and delivered in a way which ensured the welfare and safety of people. This put people at risk of receiving inappropriate and unsafe care and support. This meant the registered provider continued to breach Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010; Care and Welfare of people who use services. This corresponds to Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Risks to individuals had not been fully assessed to ensure people's safety. One person had recently moved to the service. This person had been assessed as being at very high risk of tissue damage. There was no information to guide staff about how they could help reduce the risk of tissue damage for this person. During our observations we saw they were sitting in a chair with no pressure relieving cushion. We looked in their bedroom and found an ordinary mattress on their bed. This meant we were unable to evidence that staff had taken appropriate action to help ensure this person's skin integrity and protect them from the risk of tissue damage.

Where care plans and strategies were in place to manage known risks, these were not always being followed by staff to ensure people were kept safe. For example, one person was identified as regularly making accusations against staff. They had a behaviour care plan in place which stated; "Staff to attend to all personal care in twos for protection of all involved". However, our observations, discussions with staff and review of daily care notes for January and February 2015 showed that one staff member had provided the majority of this person's personal care needs during this period. This showed us staff had regularly failed to follow the care plan and risk assessment which had been put in place to protect staff and keep this person safe.

We saw evidence that where there were identified risks to people's health and wellbeing, staff were not always able to demonstrate that they provided people with safe care and support. For example, in one person's care file we saw the district nurses had assessed the individual as needing a hoist in order to move safely. We saw there was a hoist in this person's bedroom, however, the sling which was required to move the person with the hoist was still in the plastic wrapper. We asked care staff if they used the hoist to move this person. They told us the sling was the wrong size and the individual did not like using the hoist so they used a handing belt instead. We asked if this person was weight bearing. Care staff told us they could weight bear, "Sometimes." This information was not reflected within this person's care records. We were concerned this person's moving and handling needs were not being safely met.

The provider and registered manager were not taking appropriate steps to ensure people were protected from abuse and avoidable harm. This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010; Safeguarding people who use services from abuse. This corresponds to Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found evidence care staff had not received appropriate training and development to ensure they understood and followed safeguarding procedures. We reviewed training records and saw seven out of 16 care staff had received training in safeguarding adults in 2014. This meant nine care staff had not received safeguarding training. When we spoke with care staff we found they were not able to demonstrate that they could confidently identify and respond to any concerns about peoples' welfare and safety.

Care staff told us they would always report any concerns or potential safeguarding incidents to the registered manager. A safeguarding incident is where one or more person's health, wellbeing or human rights may not have been properly protected and they may have suffered harm, abuse or neglect. However, we found evidence that care staff had not always reported safeguarding incidents to the registered manager and where they had the registered manager had not always taken appropriate action to investigate and respond to them. For example, in the daily records for one person we saw two entries from January 2015 where a person made allegations that staff members had caused them harm. For one entry care staff recorded that they had informed the registered manager of this accusation, whilst the other entry did not indicate what action had been taken in response to the allegation. We spoke with the registered manager about both allegations. They told us this person had a history of making allegations

Is the service safe?

against staff and they had spoken to the person's social worker about it. However, they were unable to show us evidence that they had investigated and reported each of these allegations to the relevant authorities such as the local authority safeguarding team and the Care Quality Commission. This meant they were unable to demonstrate that they had taken appropriate action in response to the allegations and did not have a clear audit trail of actions they had taken to minimise the on-going risk to this person and staff.

During our visit the deputy manager showed us around the building. We found areas of potential risk to people which had not been appropriately managed. These issues showed us the provider had not appropriately protected people from the risks associated with unsafe or unsuitable premises. This was a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010; Safety and Suitability of Premises. This corresponds to Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

In one person's bedroom we found a wire from the ceiling which was tucked down the side of the person's bed. The end of the wire was frayed copper wiring. The deputy manager said they thought this was an old television aerial, but was not sure as it was not connected to a plug or socket. We raised this with the registered manager and they were unable to confirm whether the wire was live or what it was required for. They said they would look into this to ensure it was safe. In the same room, the wiring in the call bell box was frayed, the wardrobe had two screws sticking out of the top and the wardrobe was not secure and moved from side to side when touched. All of these could have posed a risk of injury to people and staff when accessing this room.

In the lounge, by the entrance to the conservatory, there was a wire on the floor in front of the domestic waste bin. This could have posed a trip hazard to anyone accessing this area.

Cleaning products, including bleach, were being stored in a cupboard in the communal toilet. The cupboard had a bolt lock on it which meant it could be accessed by people who used the service. A risk assessment was not in place to demonstrate that the storage of these items in this cupboard was safe.

The call bells in people's bedrooms were not always situated where they could be easily accessed when people were in bed and one person's call bell lead was unplugged. The deputy manager explained that hourly safety checks were undertaken by night staff and they showed us records to show these checks were being done. However, they were unable to provide appropriate evidence to show that the risk of not always having access to call bells had been appropriately assessed and managed for each person.

Whilst checks were in place to ensure the water temperature did not exceed the recommended safe temperature of 43 degrees. We found the water from the hot water taps in some peoples' bedrooms, the communal bathroom and communal toilet was cold. This meant adequate provision for effective and comfortable washing was not available in these areas.

We reviewed documentation relating to the management of the premises and found there were not appropriate measures in place. For example, the gas safety certificate was dated 2 December 2013. The Health and Safety Executive guidance 'Health and safety in care homes' published in June 2014 states that all gas appliances, pipe work and flues should be checked and serviced at least once a year to ensure they are maintained in a safe and effective condition.

We saw that West Yorkshire Fire Service had issued the service with a fire safety enforcement notice on 9 July 2014. The Registered Manager told us that the fire officer had returned to the home in November 2014 and found that appropriate improvements had been made to comply with the requirements of the notice. After our inspection we checked the Chief Fire Officer's Enforcement Register and found that the notice had now been complied with.

The registered manager explained that all equipment was routinely tested for safety and suitability. For example, where people had bed rails in place the maintenance person checked they remained fit for purpose each week and all electrical equipment was tested yearly by an external contracted company. They provided documentation to show these checks were being undertaken.

Good standards of hygiene and cleanliness were not being maintained and staff demonstrated some poor infection control practices. These issues put people who used the service, staff and other people at risk of acquiring or

transferring infections. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010; Cleanliness and infection control. This corresponds to Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During our tour of the building we found some people's rooms had not been cleaned properly. For example, in one person's bedroom we found a commode next to the bed which smelt strongly of urine. When we lifted the lid of the commode we found dried urine in the bowl and lid of the commode which showed it had not been properly cleaned. The mattress smelt strongly of urine and the tiles around the sink, pipes underneath the sink, dustbin lid and windowsill were dirty and thick with dust. In another bedroom, we found a fabric chair which was stained and dirty and the toilet seat in the en-suite toilet was stained with dried faeces. This showed us that appropriate cleaning of these rooms and the equipment within them had not taken place.

We also found that bathrooms and toilets were unhygienic. We found all of the alcohol hand gel dispensers and one of the liquid soap dispensers in the bathrooms were empty. In the main bathroom we found the seal around the bath was dirty and stained brown and there was hair clogging the plug hole. The toilet seat and hinges were dirty and the underneath of the bath chair was stained brown. In the cupboard at the side of the bath we found two packets of open incontinence pads being stored on top of various toiletries, including a dirty razor. The shelf in the cupboard was dirty and some toiletries had leaked onto the shelf. This risked these items being contaminated before use. The deputy manager was unable to evidence who the toiletries and incontinence pads belonged to because they were not labelled.

In the main toilet we found a toilet brush which had brown staining to it and smelt strongly of faeces. In the disabled toilet we found the coating on the toilet seat had started to wear which meant the woodchip underneath was exposed. This meant is would have been difficult to clean effectively. There was a commode next to the toilet. The deputy manager told us that no-one currently used this and it was just being stored in this room. When we lifted the lid of the commode we found stale urine and faeces within. The deputy manager explained that commodes should be emptied down the toilet as soon as someone had used them and cleaned using the sluice. We checked the sluice and found the room was cluttered and mops and buckets were being stored on top of the sluice, which meant it was difficult for staff to access it. We also found the inappropriate storage of items within the cupboard. For example, open packets of paper hand towels, rubber gloves, clean cloths and toilet rolls were being stored next to the sluice and mops which were allocated for cleaning bodily fluids and toilet floors. This risked these items being contaminated before use.

We found staff did not appropriately dispose of and manage waste to ensure the risk of infection was minimised. We found there were no bin bags within some domestic waste bins, including the lounge and bathroom bins and we found staff had disposed of used personal protective equipment which smelt of urine, in general waste bins.

We found care staff were not all dressed in clothing which was fit for purpose and reduced the risk of the spread of infection. For example, we saw one care worker without a uniform and other care workers were wearing cardigans over their uniforms.

In the kitchen we found food was not always being stored in a way which reduced the risk of the spread of infection. For example, in the fridge we saw a packet of raw beef mince was being stored on the middle shelf next to a packet of meat pies and above an uncovered pie. This risked the contamination of the other foods items and was against current guidance from the Food Standards Agency which states that raw meat should be stored on the bottom shelf of the fridge. Following our inspection we contacted the local food safety team to tell them about these concerns.

We found there was a lack of leadership to promote, champion and challenge staff about best practice in infection control. For example, we asked the registered manager who had responsibility for infection control at the service. They said, "Well I suppose that would be me, but I haven't done any audits since September." The feedback from people, staff and health professionals was that the registered manager was not regularly present and visible at the service. This meant they did not have the time to ensure they fulfilled their role as infection control lead effectively.

Inadequate

Is the service safe?

People were not always protected against the risks associated with medicines because there were not appropriate arrangements in place to manage medicines safely. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010; Management of Medicines. This corresponds to Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During our visit we looked at the systems in place for the receipt, storage and administration of medicines. We saw a monitored dosage system was used for the majority of medicines with others supplied in boxes or bottles. We looked at the medication administration records (MAR) and checked the balances of medication being held and found some discrepancies. For example, we saw for one person 28 digoxin tablets had been received and there were 12 signatures on the MAR indicating it had been given. When we checked the stock we found there were 17 tablets left. This meant staff had signed the sheet but one dose of medication had not been given.

We checked the balance of some analgesia and found there were more tablets in the box than there should have been. When we looked at the controlled drug register we thought there was one tablet missing, however, on 28 February 2015 staff had signed the MAR chart but had not made an entry in the controlled drug register. This meant staff had not been checking the number of tablets being held, if they had been following their procedure this error would have been picked up before our visit.

We saw one person sometimes needed to have their medication administered covertly. This 'best interest' decision had been made by the registered manager, GP and the pharmacist.

We found medicines were stored safely and only administered by staff who had been appropriately trained. However, we did note only one member of night staff had received medication training. We asked the registered manager who administered the night medication when this member of staff was off duty. They told us the day staff would give out the night medication before they left their shift at 8pm.

During our last inspection we found there were not enough qualified, skilled and experienced staff to meet people's needs. During this visit we found improvements had been made to the staffing arrangements at the service. We checked staff rotas for February 2015 and found there were now typically three care staff on duty during the day. During our observations we saw this meant staff had more time to spend with people and there was a regular staff presence whilst people were in communal areas. The provider employed a cook who usually worked 10am until 1pm Monday to Friday. This meant care staff were responsible for preparing and serving food for breakfast, tea and over most weekends. Care staff also completed all laundry and cleaning as no other domestic staff were employed.

Staff told us that they had sufficient time to do all of these tasks whilst also ensuring people received support when required. The feedback from people who used the service was that overall staff provided them with support when they needed it. One person told us, "You don't have to wait for help if you need it, there is always usually someone about and they always come if you press your bell, even at night." Another person said, "Staff don't go over the top, but they are here if you need them for something and you don't have to wait too long for them to come to you." However, one person said they sometimes felt, "Rushed" by staff. Another person told us the quality of support received was depended upon which staff were on duty, they said, "Some staff are reluctant to help, but others are very willing."

The registered manager told us they regularly reviewed staffing levels based upon the needs of the people who used the service. They said that as more people moved into the home or if people's needs changed they would re-assess the dependency of the occupants to ensure they matched adequate numbers of suitably qualified care staff to ensure a safe environment.

We found there were still some areas where further improvements were required in relation to staffing arrangements The registered manager was still responsible for another service run by the provider and split their time between the two services. This meant they were not always available to provide support to staff.

Recruitment procedures were in place to ensure staff were suitable for the role. This included obtaining a Disclosure and Barring Service (DBS) check before staff commenced work. However, two of the seven staff files we reviewed were not fully up to date, for example, verbal, rather than written references had been obtained for one staff member

Inadequate

Is the service safe?

and there was no information other than a DBS check in another file. The registered manager said they would review staff files to ensure they contained all appropriate information.

Requires Improvement

Is the service effective?

Our findings

Care staff did not receive appropriate training, supervision and support to enable them to deliver safe and effective care. This is a breach of Regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010; Supporting Workers. This corresponds to Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We reviewed training records. We found most staff had not received recent training in key areas. For example, only three out of 16 staff had received training in manual handling, first aid and fire safety in 2014. We saw evidence this directly impacted on people. Our observations showed that some members of care staff did not always use appropriate moving and handling techniques when supporting people. For example, we saw two care staff assisting people to move and transfer from wheelchair to chair. We saw them supporting people underneath their arms, which is not a safe practice. We checked the training records and saw these staff had not received practical moving and handling training. One person who used the service also told us that staff were sometimes, "Rough when seeing to you."

We spoke with a member of care staff who was making people their breakfasts. They told us they had worked at the service since December 2014 but had not received any training or formal induction. We asked them if they had completed food hygiene training and they told us they had not. When we spoke with care staff they did not demonstrate a good awareness about key topics such as safeguarding and the Mental Capacity Act 2005. This risked that the correct procedures may not have been followed by staff to identify and respond to abuse and to appropriately assist people with limited capacity to make decisions.

We also found staff had not received appropriate training to ensure they could meet the specific needs of people who used the service. Our review of records and observations showed that some people who used the service lived with dementia. Training records showed that no care staff had received specific training in dementia awareness. Our observations of staff interactions with people showed that they would benefit from training in dementia awareness to ensure they provided appropriate support.

Our review of records and discussions with staff showed that regular formal supervision or appraisals did not take place. This meant there was no evidence that management had discussed individual training and personal development needs with care staff. Supervision meetings are important as they support staff to carry out their roles effectively, plan for their future professional and personal development and give them the opportunity to discuss areas of concern. This also meant there was no formal opportunity for management to discuss and deal with any performance issues and ensure a reflective approach to care.

During our last inspection we found people were not protected from the risks of inadequate nutrition and dehydration. During this visit we found some improvements had been made. We observed both breakfast and lunch and saw care staff provided people with support to ensure people ate and drank sufficient quantities. From our review of records we saw people's weights were stable, which indicated that people consumed an adequate diet. The people we spoke with did not raise any concerns about the food. One person told us, "The food is passable but not as good as I expected." Another person told us the food was, "Okay" but that, "Sometimes I could eat more than I am given." People told us they were offered choices during mealtimes and we saw evidence of this during our observations. However, we found that food options were not always offered in the most appropriate way. For example, we spoke with the cook about how they planned the weekly food menus. They asked people their preferences for meals at least two weeks in advance so that they could arrange for the food to be ordered. This may not have been the most appropriate system for people who were living with dementia.

The Care Quality Commission is required by law to monitor the Deprivation of Liberty Safeguards (DoLS). The Mental Capacity Act 2005 (MCA) sets out what must be done to protect the human rights of people who may lack capacity to make decisions. Where people's freedom is restricted in order to keep them safe the MCA states this must be authorised and reviewed in order for the deprivation of their liberty to be lawful. We saw that the registered manager had taken appropriate action to meet the requirements of the law. They were able to tell us the details of applications that had been made seeking authorisations to deprive people of their liberty. For example, one person frequently wished to leave the

Requires Improvement

Is the service effective?

building but had been considered to be at high risk should they leave the building unaccompanied. An urgent application had been made for a DoLS authorisation. This meant the registered manager knew about the legislation and were making sure they were working within the law.

In the five care plans we looked at we saw people had been seen by a range of health care professionals, including, district nurses, GPs, opticians, physiotherapists and podiatrists. We saw care workers had involved the GP in a timely way for someone who had a urine infection and another person who had a chest infection. We spoke with the district nurse who told us staff alerted them if anyone's skin stated to look red or sore and said they found the staff helpful. We also spoke with the community matron who told us staff listened to their advice and made timely referrals when required.

Requires Improvement

Is the service caring?

Our findings

We found people who used the service were not always treated with dignity and respect. This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010; Respecting and Involving people who use services. This corresponds to Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During our observations we saw people appeared at ease and relaxed in their environment. We saw some positive interactions between staff and people who used the service. We noted that staff knocked on doors prior to entering people's bedrooms and showed discretion when attending to people's continence needs. This showed us care staff were respectful of people's need for privacy and dignity. However, we found this practice was not applied consistently. For example, during the morning of our inspection we found records including the 'Toileting book' which contained personal information about people's personal care left open on top of the cabinet in the dining room. This meant it could have been seen by anyone accessing the dining room. In one person's daily notes we also found staff used disrespectful language to describe the person's behaviour such as "ratty", "rude" "snappy" and "horrible to staff".

We also some practices which showed a lack of respect for people using the service. When we looked around the building we saw poor quality towels and face cloths had been left out for people to use. We brought this to the attention of the registered manager who told us they had asked the provider for new towels but these had not been received. At breakfast time we saw one person ask for a strong cup of tea, a care worker brought them a mug of tea. The individual told them it was not strong enough but the care worker did not make them another one.

We also saw there were occasions where staff did not provide people with appropriate support and interaction. For example, in the lounge before lunch we saw three people repeatedly asking each other what was for lunch. We observed one of these people ask a passing member of care staff what was for lunch. The care staff member replied, "I don't know" and left the lounge. They did not return to explain to people what the lunch time options were. Shortly before lunch was served we saw one person leave the dining room. They appeared anxious and unsettled. They walked up and down the corridor and lounge saying, "I have lost my handbag, I can't find my handbag." A member of care staff walked past and said, "Oh dear" but did not provide any further support or assistance to reassure or calm this person. They remained unsettled until an inspector spoke with them to say they had seen them take their handbag into the dining room.

Care records had been written and reviewed by staff. Care records did not always demonstrate that people had been involved in planning their care. People we spoke with told us they did not always feel involved about how their care was planned and delivered because they were not always provided with appropriate information. For example, we spoke with two people who told us they had been moved from an upstairs room to a smaller room downstairs. They told us they had been moved for "health and safety reasons" but were unclear about what these reasons were and felt this had not been fully explained to them. They told us they were going to speak to the registered manager about this. When we spoke with the registered manager they told us they had not yet had chance to speak with these people but knew they were upset about having to move rooms.

During our review of care records we found some information about people's life histories and personal preferences. This information helped staff better understand the person they were caring for, including their personal preferences and values. When we spoke with care staff we found they had knowledge about people and how they liked to be supported. However, we found the information staff told us was not always reflected in people's care records and how they delivered care and support to people.

Overall people told us they were well cared for and liked living at the service. We spoke with two visitors who told us they felt their friend's well-being had improved and they were more settled since they moved into the service.

Requires Improvement

Is the service responsive?

Our findings

We found people did not always receive care that was personalised and responsive to their individual needs. People's care needs had not been adequately assessed and delivered in accordance with their individual needs. This put people at risk of receiving inappropriate and unsafe care and support. This meant the registered provider continued to breach Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010; Care and Welfare. This corresponds to Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service did not always appropriately respond to people's changing needs. For example, one person had been seen by the specialist speech and language team (SALT) in December 2014. The SALT had advised they needed to have thickened fluids and a mashed diet to help reduce the risk of them choking. Our observations and review of this person's food diary showed they were given un-thickened fluids and a normal diet. We spoke with care staff about this. They told us this person did not like thickener in their fluids or a mashed diet. Staff had not raised this with the speech and language therapists to look at the risks associated with the person's refusal to comply with their advice. This person's care records had not been reviewed and updated to reflect what was happening in practice. There was also no evidence they had spoken to this person to explain the potential risks of them refusing to follow the specialist's advice or to seek their views about the food and drink options recommended by the SALT so that appropriate changes could be implemented.

We were not always able to find evidence people had received appropriate support to meet their personal care needs. One person told us they were not always able to have a bath or shower as often as they would have liked. Their bathing record showed they had received one bath or shower a month in the four months prior to our visit. Another person had been admitted to the service the week before our visit. We looked in their bedroom and found their toothpaste and toothbrush were still in their original packages. We also found the hot water was luke warm and there was no plug in their wash hand basin. We asked the registered manager how staff would have supported this person to have a wash and clean their teeth. They told us they did not know.

When we arrived at the home at 8.10am we found most people were up and dressed for the day. When we spoke with care staff they told us this was usual but that it was people's preference to get up early. In the dining room we saw there was a notice on the wall titled, "Jobs to do; morning shift and afternoon shift". This detailed the suggested routine staff were to follow. Such as; "8.30am bring everyone through for breakfast. 9am assist residents back to the lounge. 10am one member of staff to do drinks. 10.15am one member of staff to do activities". The registered manager said they regularly reminded staff of the importance of accommodating people's personal requests. However, we found this was not being translated into practice. We found care staff were focused on routines, rather than delivering person centred care. For example, when we spoke with one care staff member about a person's morning routine they explained how this person had struggled to get up early on a morning but were now in more of a routine. They said, "When they first came here they were not used to it and they just wanted to sleep, they are good now." When we reviewed people's daily notes we also saw staff had written entries such as that people had "refused to get up." This showed us that the staff culture was not focused on the delivery of person centred care.

We spoke with people about the activities they liked to do. One person said, "We usually just watch telly, but we will fit in with anything." Another person said they would like to get, "Out and about more often." On the morning of our visit a care staff member played skittles with some people in the lounge. Two people were also sat listening to music which they told us they enjoyed. However, throughout the day we found a lack of meaningful occupation for people and most staff interactions were centred on care tasks. We saw staff had supported people to go to the seaside in September 2014. The feedback was that this was a trip which people had really enjoyed. However, we found little evidence of community involvement or people being supported to do activities outside of the home since then, despite people saying this is something they would enjoy.

We found there were mechanisms in place to obtain people's feedback. This included residents' meetings and surveys. The registered manager told us they usually responded to and investigated complaints. They said they tried to deal with any issues people raised informally and in person where possible. However, there was a complaints process available should people wish to raise a formal complaint. We reviewed a recent complaint. We saw the

Requires Improvement

Is the service responsive?

registered manager had responded to the complainant with a written apology and details of how they had investigated and responded to the issues raised. The registered manager explained they had ensured any lessons learned were fed back to care staff to ensure reflective practice and that similar issues did not occur again. We saw evidence of this in the staff meeting minutes we reviewed. We did not see any trends or patterns in the complaints reviewed.

Inadequate

Is the service well-led?

Our findings

We found inadequate systems in place to ensure the delivery of high quality care. These included; management of safeguarding, the medicine management system, managing risks to people, care and welfare, staff training and support, infection control and the safe management of the premises. These issues had not been identified or addressed prior to our visit, which demonstrated an absence of robust quality assurance systems. As part of a robust quality assurance system the registered manager and provider should actively identify improvements on a regular basis and put plans in place to achieve these and not wait for the Commission to identify shortfalls. This meant the registered provider continued to breach Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010; Assessing and Monitoring the quality of service provision. This corresponds to Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

A registered manager was in place on the date of the inspection. However, the service was not well-led. The manager was also registered manager for another of the provider's services. This meant they were unable to fully dedicate their time to ensure the consistent and effective management of Oakleigh Care Home and the leadership of staff. The feedback from staff, health professionals and people was that the registered manager was not often present and the deputy manager was in charge of most of the day to day running of the service. However, the deputy manager worked on the rota as a carer most days. The registered manager said they visited the service most days, however, they saw the other service as, "My baby." They had originally agreed to take on the management of this service for a year until the provider had found an alternative manager. They had been in post for 15 months and said there was now too much going on to enable them to manage both locations and perform all of their duties in each effectively. They said they had raised this with the provider but were not aware that they had identified anyone to take over the management of this service.

The provider did not have a formal system to assess and monitor the quality of care provided to people or to manage risks of unsafe or inappropriate treatment. There was no evidence of recent quality monitoring of care documents at the home. We saw care plan audits had been undertaken in November 2014, however, there were no more recent checks than that. These checks were not robust or effective because they did not identify which care plans had been looked at. We asked the registered manager about this and they were unable to tell us which care plans had been reviewed. This meant we were unable to track back to check that appropriate improvements had been made. During our review of records we found some care plans lacked detail and others did not contain appropriate advice for staff to follow. During our observations and review of records we also found various instances of care not being delivered in line with people's care plans. These issues could have been identified through a formal system to assess and monitor the quality of care.

Risks to people's health, safety and welfare were not appropriately reported, managed and analysed. The records of accidents and incidents did not contain sufficient detail to demonstrate that appropriate preventative action had been taken to manage and reduce risks to people. For example, we saw an entry in the accident book where one person had fallen in the lounge in September 2014. The accident form detailed that staff had checked this person for injury but there was no other information of action staff had taken. We reviewed this person's falls risk assessment moving and handling care plan. Both had been reviewed since the fall, however, staff had written "no change." There was no information within the care records to highlight that this person had fallen or to demonstrate that staff had reviewed their risk of falls or moving and handling needs since the fall. This meant we were unable to demonstrate that staff had taken appropriate action since the incident to reduce the risk of future falls.

We also found staff were not consistently following procedures to ensure accidents were correctly recorded and reported. We found an entry in one person's daily notes which showed they had fallen whilst being supported by staff. Staff had recorded that they had told the deputy manager about the fall and sought their advice regarding treatment. However, this incident was not recorded in the accident book and when we spoke with the registered manager they were not aware of it. They said staff should have informed them and completed the accident book so that they could check that appropriate action had been taken. Another entry in the accident book detailed a fall a person had in October 2014. It was not clear from the

Is the service well-led?

details recorded that this person had sustained a fractured femur as a result of this fall. Without complete and consistent records the registered manager was unable to effectively analyse incidents to ensure any trends or patterns were identified and appropriate action was taken in response to them to protect people from harm.

We found people were not consistently treated with dignity and respect and we observed some poor care practices such as inappropriate moving and handling techniques. These issues could have been identified and addressed through formal observations of staff. However, there was not a formal process in place to check staff were following correct processes or to check their practices were safe.

We found a lack of robust quality assurance with regards to infection control. Care staff were responsible for completing all cleaning in the home. However, they did not have their work regularly checked to ensure it had been completed to an appropriate standard. The deputy manager told us they usually checked the rooms each shift to ensure staff had completed their cleaning these checks were not recorded. When we checked the daily cleaning records were found gaps where staff had not recorded that cleaning had been completed. For example, the week commencing 12 January 2015, there were two consecutive days where staff had not signed to show their cleaning had been completed. This meant we were unable to evidence that appropriate cleaning had taken place on those days. These errors had not been identified and addressed through an effective system of audit. The registered manager said they had last completed an infection control audit in September 2014 however they were unable to locate this on the day of our visit. There was no other evidence of any more recent infection control audits or environmental audits to monitor cleanliness and hygiene in the home on an on-going basis.

We found where issues or improvements had been identified, timely action had not always been taken to address them. For example, we saw an entry in the maintenance book from 11 December 2014 which stated that restrictors were required for all windows in the home. There was no other information recorded to demonstrate what action had been taken in respect of this. The registered manager said they were unsure what action had been taken and would have to check with the provider. During the inspection they telephoned the provider who informed them that window restrictors were on order. However, they were unable to provide us with evidence of this during our visit. We also saw that the issues relating to the water only being tepid in most of the downstairs bedrooms had been identified by the registered manager in December 2014. However, we found this was still an issue on the day of our visit.

We spoke with the registered manager and care staff about the support they received from the provider. They said the provider visited the home most weeks and completed a formal audit of the service at least every three months. The registered manager said they had audited the service in December 2014 but they had not yet received a copy of the provider's report. We looked at copies of provider audits from September and October 2014. We saw they checked a range of issues, however, they were not always effective in identifying where improvements were required and ensuring these were addressed. For example, the audit for October 2014 stated, "Training matrix up to date. Supervision ongoing." However, we found significant gaps in staff training and an absence of staff supervisions. Also, whilst the provider checked the minutes of the residents' meetings and surveys, there was no evidence they had taken the time to speak with people who used the service to seek their views of where improvements may have been required.

In our last inspection report we asked the registered manager to ensure they reviewed their procedures to ensure appropriate referrals and notifications to the Commission were made. From the information we hold about this service we know that the registered manager had informed the Commission about some incidents which had occurred, such as where people had sustained injuries. However, we found safeguarding incidents were not always being reported to the local authority Adult Protection Unit and to the Commission. If referrals were not made this meant external agencies were unable to effectively monitor issues and decide if a plan to keep people safe was required. We found one person had made three allegations that they had suffered harm as a result of staff practices. These are all examples of safeguarding incidents which both the Commission and the local Adult Protection Unit should have been informed of, but were not. Following our inspection we wrote to the provider and the registered manager and reminded them both of their duty to ensure they notified the Commission of such incidents. We

Inadequate

Is the service well-led?

explained that if we found evidence they had failed to notify the Commission of these incidents in the future this could result in enforcement action being taken against them.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment The registered person had not made suitable arrangements to ensure that people were safeguarded from the risk of abuse. This was a breach of regulation 11 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010; Safeguarding people who use services from abuse. This corresponds to Regulation 13 (1) (2) and (3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment People were not protected against the risks of acquiring an infection as the maintenance of appropriate standards of cleanliness and hygiene were not consistently being met and sustained. This was a breach of Regulation 12(1)(a)(b) and 12(2)(c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010; Cleanliness and infection control. This corresponds to Regulation 12 (2)(h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment

This section is primarily information for the provider

Action we have told the provider to take

The registered person had not ensured that people were protected against the risks associated with unsafe or unsuitable premises.

This was a breach of Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010; Safety and suitability of premises. This corresponds to Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing The registered person did not have suitable arrangements in place to ensure the people they employed were appropriately trained and supported to enable them to deliver care safely and to an appropriate standard. This was a breach of Regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010; Supporting Workers. This corresponds to Regulation 18 (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect The registered person had not made suitable arrangements to ensure the dignity, privacy and independence of people. They did not ensure people were treated with dignity and respect or that people were provided with appropriate information and support in relation to their care or treatment. This was a breach of Regulation 17(1) and (2)(a)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010; Respecting and involving people who use services. This corresponds to Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The registered person had not ensured people were protected against the risks associated with the unsafe use and management of medicines. This was a breach of Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010; Management of medicines. This corresponds to Regulation 12 (2) (f) and (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services People were not protected against the risks of receiving care or treatment that was inappropriate as care was not planned and delivered in such a way as to meet individual needs and ensure the welfare and safety of people. Regulation 9 (1)(a)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010; Care and welfare of people who use services. This corresponds to Regulation 9 (3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:
We served a warning notice on the registered provider stating that they are required to become compliant with this regulation by 8 May 2015.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers The registered person had not protected people against the risks of inappropriate or unsafe care and treatment, as it was not regularly assessing and monitoring the quality of services provided, nor identifying, assessing and managing all risks relating to the health, welfare and safety of service users. There was no effective analysis of incidents that resulted in, or had the potential to result in, harm to a service user. Regulation 10 (1)(a)(b) and (2)(c)(i) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010; Assessing and monitoring the quality of service provision. This corresponds to Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:
We served a warning notice on the registered provider stating that they are required to become compliant with this regulation by 8 June 2015.