Saffron Care Ltd

Oakhurst

Inspection report

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Ratings

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

Overall summary

Oakhurst is registered to provide accommodation and personal care for up to 16 older people. Nursing care is provided by the local community nursing team. Oakhurst primarily provides accommodation and personal care for people with dementia. It is part of the Saffron Care Ltd group which has one other care home and a Domiciliary Care Agency registered with CQC.

This inspection took place on 4 and 13 March and 20 April 2015 and was unannounced. There were ten people living at the home. The service had last been inspected on 3 September 2014 when it met all regulations in the areas looked at.

It is a condition of the home's registration that a registered manager be employed at the home. There had been no manager registered for the service since 27 June 2014. On the first day of our inspection a manager had been appointed but had not yet registered with the Commission. They were not available on the second day

Summary of findings

of our inspection and had left their employment with the service by the third day of our inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Prior to this inspection concerns had been raised about the care provided to people. This included care of pressure areas and staff not following the guidelines set by healthcare professionals. This had resulted in individual safeguarding alerts being raised. The investigations into these alerts were still on-going at the time of our inspection. Following these alerts being raised, the local authority had placed a ban on admissions to the home. After our second day of inspection further concerns were received, which had led to the commissioners for the service sending in their CRT (Crisis Response Team) to keep people safe. Following our third visit the commissioners made a decision to terminate their contract with the service. Everyone living at the home had been supported to find alternative accommodation and the home is now empty. The registered provider has since applied to the Care Quality Commission to remove the location Oakhurst from their registration and close the home.

The service was not well led. There had been no person regularly managing the service since the previous registered manager had left the service in December 2013. They had not deregistered until June 2014. Although the registered provider visited the service on a regular basis they had not identified the issues we raised in this report. This was because there was no effective system in place to monitor and improve the quality of care at the service.

People were not safe and were not protected from the risks of harm. One person had developed pressure sores due to them not being turned often enough and by the use of incorrect equipment. Another person's ability to move had been affected and it was no longer possible to move the person to their chair, because staff had not followed a plan put in place by an occupational therapist. People's emergency evacuation plans did not identify the nearest evacuation point, which meant staff did not have the necessary information to safely evacuate the building in an emergency such as a fire. People were protected from the risks of cross infection.

People's medicines were not managed well. The variable dose of one person's medicine was not recorded in a place that was easy to find and not all handwritten entries on Medication Administration Record (MAR) charts were double signed. This meant people were at risk of receiving incorrect doses of medicines.

People were not protected by the service's recruitment procedures. There were no dates for staff's previous employment. This meant it was not possible to discuss any gaps in their employment history. Not all staff had a start date recorded so it was not possible to see if a criminal records check had been obtained before they started work. However, staff had received training in safeguarding people and demonstrated a good knowledge of different types of abuse.

Staffing levels were not adequate for the number of people living at the service. One member of staff had to stay in the lounge at all times (an agreement with the local authority commissioners). This reduced the numbers of staff available to ensure people had the opportunity to participate in regular activities and social interaction. The registered provider had not increased staffing levels in response to this condition being placed on the contract. For example, people who spent all their time in their rooms had limited time spent with them other than when staff were attending to their personal care.

Care plans were large documents and it was difficult to find the most relevant up to date information. There was limited evidence that people or their relatives, were involved in planning their care. There was inconsistency about how people's needs were assessed, planned for and reviewed. For example, it was not possible to accurately assess people's nutritional and fluid intake to ensure their health was maintained. It was not possible to determine if people had received adequate amounts of food and fluid.

People did not receive effective care and support from staff who had the skills and knowledge to meet their needs. Staff had received training in many areas but there

Summary of findings

was no effective system in place to ensure they were putting their learning into action. Some staff had received supervision. However, this was not on-going and did not ensure staff's competence in their role was maintained.

Staff were not always respectful of people's dignity. For example, we heard people who needed help to eat being referred to as 'the feeds'. However, staff were kind and caring and good relationships had been built between staff and the people they cared for. People appeared well cared for and looked clean and tidy.

Staff had an understanding of the Mental Capacity Act 2005 (MCA) and ensured they obtained people's consent before providing personal care. Where people lacked the capacity to consent to care or treatment steps had been taken to ensure decisions were taken in the person's best interest. Where appropriate Deprivation of Liberty Safeguards (DoLS) authorisations had been obtained from the local authority to ensure people did not leave the building unescorted in order to keep them safe.

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

The overall rating for this provider is 'Inadequate'. This means that if the home does not close it will be placed into 'Special measures' by CQC. The purpose of special measures is to:

- Ensure that providers found to be providing inadequate care significantly improve
- Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.
- Provide a clear timeframe within which providers must improve the quality of care they provide or we will seek to take further action, for example cancel their registration.

Services placed in special measures will be inspected again within six months. If insufficient improvements have been made such that there remains a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. The service will be kept under review and if needed could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement we will move to close the service by adopting our proposal to vary the provider's registration to remove this location or cancel the provider's registration.

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?
The service was not safe.

People's medicines were not managed safely.

People were not protected from the risks of improper treatment.

People were not protected by robust recruitment procedures.

Risks to people's health and welfare were not well managed.

Inadequate

Is the service effective?
The service was not effective.

People were not supported by staff that were trained and knowledgeable in how to care and support them.

People were supported to access a range of healthcare services, but professional advice was not always followed.

People's nutrition and hydration needs were not well monitored.

People were asked for their consent before staff provided personal care.

People were supported by staff who displayed a good understanding of the principles of the Mental Capacity Act 2005 and the associated Deprivation of Liberty Safeguards act, which had been put into practice.

Inadequate

Is the service caring?
Some aspects of the service were not caring.

People were not always spoken of in a respectful manner.

People and their relatives were not supported to be involved in making decisions about their care.

People's needs were met by kind and caring staff.

People's privacy was respected and all personal care was provided in private.

Requires improvement

Is the service responsive?
Some aspects of the service were not responsive.

People's care plans were confusing and were not reviewed regularly.

People's experience of social interaction and activities was mixed.

Visitors told us they could visit at any time and were always made welcome.

Inadequate

Is the service well-led?
The service was not well led.

Inadequate

Summary of findings

There had been no registered manager at the service since June 2014 and no regular manager had been in place since then.

There was no effective system in place to monitor and improve the quality of care.

Issues identified during this inspection had not been identified by the registered provider.

Oakhurst

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 4 and 13 March and 20 April 2015 and was unannounced. The inspection team consisted of two Adult Social Care (ASC) inspectors.

Before the inspection we gathered and reviewed information we hold about the provider. This included information from previous inspections and notifications (about events and incidents in the home) sent to us by the provider.

During the inspection we spoke with four people using the service, one visitor, five staff, the manager and the registered provider. We also spoke with five health and social care professionals and staff from the local authority who had commissioned some placements for people living at the home.

We observed the interaction between staff and people living at the home and reviewed a number of records. 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 talk to us. The records we looked at included three people's care records, the provider's quality assurance system, accident and incident reports, three staff's records, records relating to medicine administration, staffing rotas and training records.

Inadequate

Is the service safe?

Our findings

People were not safe and were not protected from the risks of harm. One person had developed pressure sores. The person had been assessed as being at 'high risk' on 23 October 2014.Some pressure relieving equipment recommended for use for people with medium level risks had been used. The Community nursing team had been called in by staff at the service to look at a blister on the person's foot on 2 January 2015 and they completed a wound assessment on 6 January 2015. However, the home did not provide equipment for the use of the person at high risk of developing pressure sores until 13 January 2015. Staffing levels had been reduced over the weekend starting 2 January 2015 which had resulted in the person not being moved on a regular basis to relieve pressure on the affected areas. A safeguarding alert had been made in relation to these concerns and was being investigated by the local safeguarding team.

Another person had received an assessment from an Occupational Therapist. A plan had been put in place for staff to transfer the person from their bed to a specially adapted chair each day. This plan was not followed consistently by staff. As a result the person's ability to move had been affected and it was no longer possible to move the person to their chair. Staff told us they thought they were doing the best for the person who appeared to be in pain when moved. However, they did not consult with health care professionals before they stopped following the plan. A safeguarding alert had been made in relation to these concerns and was being investigated by the local safeguarding team.

This was a breach of regulation 13(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Other risks to people had been identified but had not been managed appropriately. For example, people had a Personal Emergency Evacuation Plan for use in the event the building needed to be evacuated. However, the plans did not contain all the information staff needed to safely evacuate people. All the plans stated staff should 'Assist (the person) to the nearest evacuation point' but did not say where the nearest evacuation point was.

Medicines were not being managed appropriately and people were at risk of not receiving the correct dose of medicine. For example, on the first day of our inspection staff could not tell us what dose of a particular medicine had been prescribed for one person. The dose was not recorded on the person's Medication Administration Record (MAR) chart, but was eventually found recorded in the diary. Doses for this particular medicine often change following blood tests, so it is vital that doses are accurately recorded and easily obtainable.

Handwritten entries made on MAR charts had not been signed by the staff member making the entry. Two signatures are required for all handwritten entries to MAR charts to show that information about what had been prescribed had been accurately recorded. Quantities of medicines received into the home had not always been recorded onto the MAR charts.

This was a breach of regulation 12(2)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The afternoon medication round was observed on the third day of our inspection and people were seen to receive their medicines safely. Records relating to the application of topical creams were held in people's bedrooms and completed daily.

People were not protected by the service's recruitment procedures. The registered provider did have a policy which should have ensured all employees were subject to the necessary checks which determined that they were suitable to work with vulnerable people. However, two of the three files we looked at did not contain a start date for the staff and the manager could not confirm the dates. This meant it was not possible to confirm the checks had been obtained before the staff started work. Also none of the application forms contained the dates when staff had worked at any previous employment. Therefore it was not possible to identify any gaps in their employment history and discuss reasons why there may have not worked during these gaps.

This was a breach of regulation 19(3)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

All three staff files contained references and criminal records checks.

Staff had received training in safeguarding people. The manager was aware of their duty to report any allegations

Inadequate

Is the service safe?

of abuse to the local authority safeguarding teams. Staff demonstrated a good knowledge of different types of abuse. They told us how they would recognise abuse, and what they would do if they suspected abuse was occurring within the service. They said initially they would tell the manager, but knew they could also contact the police or the local care management teams. However, staff had not recognised that not following people's care plans placed them at risk of harm.

On all three days of our inspection there were three care staff on duty. There was an agreement in place between the registered provider and the local commissioning team that there would be one member of staff in the lounge when people were using it. This was because people had been assessed as being at high risk from falls. This restricted the number of staff available to meet the needs of those elsewhere in the home, such as those who were being nursed in bed or who preferred to remain in their rooms. Since our third day of inspection we have been told that four care staff are on duty during the day time.

People were protected from the risks of cross infection. Staff had received training in infection control. There were stocks of disposable gloves and aprons around the home and staff were seen using them appropriately. The home was clean and tidy and there were no unpleasant smells.

Inadequate

Is the service effective?

Our findings

Improvements were needed to the way people's care was planned, recorded and delivered. People's healthcare needs were not always met. The environment was unsuitable for people living with dementia.

People did not receive effective care and support from staff with the skills and knowledge to meet their needs. This was because although staff had received training there was no effective system in place to ensure they were putting their learning into action.

Some staff had received supervision. However, this was not ongoing and did not ensure staff's competence in their role was maintained.

This was a breach of regulation 18(2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff training records showed that staff had received training relating to their roles and responsibilities. This included training to keep people safe including moving and transferring, infection control, food hygiene, medication administration and fire safety. In addition, records showed that staff had completed training in dementia care and equality and diversity. There was a system in place to identify when any training was due to be updated.

Staff were knowledgeable about people's daily care needs but there was inconsistency about how these needs were assessed, planned for met and reviewed. For example, it was not possible to accurately assess people's nutritional and fluid intake to ensure their health was maintained. Care plans were very large documents, contained some confusing information and had not been regularly reviewed. For example, one person's care plan for personal care had not been reviewed since 13 January 2015. Staff had not followed people's care plans in relation to pressure area care which had resulted in the person developing pressure sores.

People's nutritional needs were not appropriately monitored to ensure they had enough to eat and drink. Several people required their nutritional and fluid intake to be monitored each day. Records indicated some people had not had enough to eat or drink. These people were at risk of becoming dehydrated and malnourished and the only way to check they had enough to eat and drink was through records. The records for one person indicated they had something to eat at 5pm in the afternoon and then nothing until 11am the following morning with no indication if food was offered but refused. Entries also included 'bowl of Weetabix, milk, sugar', and, 'bowl of cottage pie and mixed veg' but not always how much of this was eaten. Where an indication that half or all of a meal had been eaten, there was no indication of the portion size of the meal. Records of how much people had to drink were had not been completed to show risks were being managed effectively. For example, one record indicated a person had received a drink at 6pm and then not again until 10:45pm with no indication of whether a drink was offered but refused. Staff were not able to say how much this person should be drinking each day and totals for how much had been drunk over a 24 hour period were not recorded. This lack of effective monitoring meant vulnerable people were at risk of not receiving sufficient amounts to eat and drink.

Staff recorded people's weight each month as an additional method of monitoring their health and wellbeing. However, there was continuing inconsistencies in how the results were reviewed with no actions identified when weight loss had been recorded. For example, one person had lost 1.9Kg in weight over 24 days but there was no evidence any action had been taken to address this.

One person living at Oakhurst had diabetes controlled by diet. Their care records did not provide guidance for staff regarding how their diabetes should be monitored and whether blood glucose levels should be checked periodically. Guidance staff had downloaded from the internet and held in the person's care file indicated people with Type II diabetes (diet controlled) should have their blood glucose levels checked two to six monthly. There was no indication whether this was required for this person or not. Their care records indicated they required a "healthy diet with reduced sugar intake" but there was no guidance for staff about what signs and symptoms to look for should the person's blood sugar become unstable, or how to monitor their food and fluid intake. Staff were aware the person was diabetic and that food should be monitored. However, they did not know the types of food the person should or should not receive. These inconsistencies and lack of monitoring placed people at risk from deteriorating health.

Inadequate

Is the service effective?

This was a breach of regulation 12(1)(2)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People said they enjoyed the food and had plenty to eat. They said they could choose what they wished to eat and could have drinks and snacks throughout the day. The cook told us they did not use set menus. They discussed what food was available with people and then decided what to cook.

Staff did not always follow the advice given by visiting healthcare professionals. One person was no longer able to get out of bed because staff had not followed the occupational therapist's plan. However, people did have access to healthcare professionals and records indicated that people had been visited by GPs, Community Nurses and occupational Therapists. We spoke with a visiting GP who told us they had always found staff to be prompt in requesting help and advice and had always followed any instructions. They said they had always found staff to be kind, respectful and helpful and never appeared rushed.

The environment was not suitable for people living with dementia. Accommodation was provided over four floors with a stair lift providing access to each floor. The accommodation was suitable only for people who could manage to climb stairs or use a stair lift. Those people unable to do so were either confined to their room or have to exit the building on one level to regain access to the building on another. This limited some people's independence as it was unsafe for them to move around in this area on their own.

The level of lighting around the home could not be adjusted, toilet doors were not painted in a single distinctive colour with clear signs and there was no independent access to outdoor space for people. There were few signs around the building to enable people to find toilets or their bedrooms.

This was a breach of regulation 15(1)(c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was a noticeboard in the lounge that displayed the date and the type of weather for the day. The dining room had a series of photographs of film stars from the 1940s and 1950s and these were used to stimulate chat between staff and people living at the home.

Staff had an understanding of the principles of the Mental Capacity Act 2005 (MCA) and how to make sure people who did not have the mental capacity to make decisions for themselves had their legal rights protected. The MCA provides the legal framework to assess people's capacity to make certain decisions, at a certain time. When people are assessed as not having the capacity to make a decision, a best interest decision should be made involving people who know the person well and other professionals, where relevant. Staff told us that people would be able to tell them if they did not want or like something. However, people may not be able to consent to more significant decisions, such as medical treatment.

Throughout our inspection people were offered choices about what they wanted to drink and eat and where they wanted to spend their day. Staff asked people for their consent before providing care. For example, staff asked people if they could assist them to move from chairs to wheelchairs and vice versa.

Where people were not able to make significant decisions, an assessment of the person's capacity to make the decision had been undertaken. If the person was assessed as not having capacity to make the decision, other people were involved to determine what decision would be in the person's best interest. This procedure had been followed where people did not wish to take medicines. This demonstrated staff understood the principles of the MCA and consulted relevant people, where appropriate, to make a decision in the person's best interests.

The MCA also introduced a number of laws to protect individuals who were, or may become, deprived of their liberty in a care home. The safeguards exist to provide a proper legal process and suitable protection in those circumstances where deprivation of liberty appears to be unavoidable and in a person's own best interests. There has been a recent change to the interpretation of the deprivation of liberty safeguards and the manager was aware of the need to make appropriate applications to the local authority in order to comply with the changes. This was because the external doors to the home were kept locked to restrict people from leaving the home on their own. One person had a relevant authorisation to deprive them of their liberty in place. Staff acted in accordance with the details contained within the authorisation.

Requires improvement

Is the service caring?

Our findings

Improvements were needed to the way in which people's dignity was respected.

Some staff were not always respectful to people's dignity. Some of the words staff used to describe the people living at Oakhurst were disrespectful and depersonalised. For example, one member of staff was heard to refer to the people who required assistance with eating as "the feeds".

We spoke with seven people all of whom had some degree of dementia. People could not answer detailed questions but we saw that good, positive relationships had been formed between staff and people. They were all happy and smiling and appeared to enjoy the staff's company. People told us they were happy and they liked the staff. We heard pleasant conversations between people and staff whilst going about the home.

All personal care was provided in private. People were dressed appropriately and their clothes were clean and tidy which told us that staff had taken care to ensure people's personal needs were met. People were treated with respect and as individuals. Staff enabled people to maintain as much independence as possible and offered choices throughout the day. Staff listened to people and supported them to express their needs and wants. Any personal care that was offered was done so in a discreet manner.

On the first day of our inspection, people had a light lunch as staff were buying them a 'chippie tea'. People had told staff they would like fish and chips for tea sometime, so staff were going to get fish and chips from a local shop.

Staff were aware of issues of confidentiality and did not speak about people in front of other people. When they discussed people's care needs with us they did so in a respectful and compassionate way.

We spoke with one visitor who told us they visited about once a week and were always made welcome. They said that staff were always "so kind and happy", "patient" and a "lovely group".

We recommend that the provider explores the SCIE guidance on Dignity in Care to ensure people's privacy and dignity is maintained at all times.

Inadequate

Is the service responsive?

Our findings

Improvements were needed to care plans to ensure correct and sufficient information was recorded to help staff meet people's needs in a individual and personal manner. People and their relatives were not routinely included in the planning of care needs. The opportunity to participate in social activity was limited.

We identified concerns in relation to the monitoring of what people were eating and drinking.

There was insufficient and, at times, conflicting guidance for staff on how to manage people's nutritional needs. For example, in one person's care file three separate documents were found relating to eating and drinking. The first identified the person needed help with their meals and stated 'I need help with my eating and drinking, but there was no further description about what help was required. The second document indicated the person had no difficulty with swallowing but required prompts with meal. A third document, an assessment from the Speech and Language Therapy Service, identified the person was at risk from aspiration due to poor swallowing and required a pureed diet and thickened liquids. Staff were aware of the person's needs and were able to describe how meals and drinks should be prepared and how they should support this person. However the lack of easily accessible, clear guidance placed this person at risk of aspiration and choking.

This was a breach of regulation 17(2)(c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Each person had a care file containing documents relating to their care needs. These files held information dating back several years and those documents relating to current care needs were not easily identifiable. Where care needs were identified they were not described in sufficient detail to allow staff to support the person with consistency and in the person's preferred manner. One person's care plan for personal care had not been reviewed since 13 January 2015.

There was no evidence that the service regularly asked people for their views and experiences of the care provided. No regular meetings were held to obtain the views of people or their representatives. The last time people's representatives had been asked for their views of the service was when questionnaires were sent out in September 2014. Only one response had been received and this commented that items of clothing had gone missing or been ruined in the laundry. The registered person told us the matters had been resolved, but the person no longer lived at the home so we could not discuss this with them.

There was limited evidence that people were supported to express their views or were involved in making decisions about their care, treatment and support. For example, there was little evidence recorded on care plans that people or their representatives had been involved in completing the plans. One visitor told us that they didn't get involved in planning care as the person they visited was a friend. However, they thought the person's relative was involved in some aspects of care planning.

It is important for staff to have a good understanding of people's mental health needs as well as their medical and personal care needs. This is particularly important as many of the people living at Oakhurst have a diagnosis of dementia and are unable to communicate their needs. Documents relating to mental health needs did not always seek information about people in a respectful manner. One of the documents asked the question, 'fits in, no problems?', and another asked if the person needed 'trailing and checking', rather than assessing how the person might be supported to live in an unfamiliar place.

People's care files held a document entitled "This is me" designed to allow staff to record a person's care needs and other information relevant to their care such as their past history and social interests. The information in these files did not provide staff with a clear understanding of the person's needs, how they wished to be supported, or how staff should promote and protect the person's independence. For example, one person's file recorded their needs as 'helping me wash and dress', and 'my food I need helping with now'. There was no description of what the person was able to do for themselves and how staff should support them. Also in answer to the question, 'what makes me feel better if I am anxious or upset?, staff had recorded 'afraid of the dark. In response to the question 'how can we communicate', staff had recorded 'I do shout sometimes'. These records provided no guidance for staff on how to support someone when they become distressed or how best to communicate with someone living with dementia. There was no understanding of how to correctly use the document.

Inadequate

Is the service responsive?

This was a breach of regulation 9(3)(a)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's religious and spiritual beliefs were recorded in their care files but there was no information about how to support people in continuing to follow their faith. For example, one person's care file recorded 'Christian Church' in response to the question about their beliefs, but no further information was available about whether the person would like to attend the local church or whether services were held in the home.

People's experience of social interaction and activities was mixed. Social engagement was limited and irregular depending on where people spent their time. Those people who were in the lounge were able to engage in a series of activities, including quizzes and skittles. However, staff told us that they had little time to spend with people who were unable or chose not to leave their rooms.

On the second day of our inspection we spent some time in the lounge conducting a Short Observational Framework for Inspection (SOFI). There were five people sat in the lounge at the time, while other people were in their rooms. There was good interaction between people and staff and everyone in the lounge was encouraged and supported to participate in the activities. During a game of skittles there was much competition between everyone to knock over the most skittles. Staff encouraged people to chat about other times they had played such games. There was friendly and appropriate chatter and laughter. Staff also encouraged people to talk about other things they had enjoyed doing before moving in to the home. On the third day of our inspection we heard that people had chosen to watch a DVD in the morning. However, people missed the end of the film as they were called into the dining room for lunch.

The registered provider told us they had not received any complaints since our last inspection. There was a system in place should anyone wish to make a complaint.

Inadequate

Is the service well-led?

Our findings

The service was not well led. There was no registered manager for the service and no application to register a manager had been received. The manager told us that they had been managing the home since September 2014 and applied to become registered, but this had been rejected because the information was incomplete. Following the first day of our inspection the manager had left their employment with the service. The previous registered manager had deregistered in June 2014, but had not worked at the home since December 2013. It is a condition of the service's registration that a manager is registered.

Since December 2013 there had been a series of concerns raised with the Care Quality Commission about care at the service. This had led to enforcement action being taken in May 2014. Major concerns were identified at our inspection in July 2014, which had been rectified by September 2014. This inspection in March and April 2015 was initiated in response to concerns about people's care. The lack of leadership and management had meant the service was unable to keep people safe or maintain any improvements.

Following our third visit to the service, local authority commissioners made a decision to terminate their contract with the service. Everyone living at the home had been supported to find alternative accommodation and the home is now empty. The registered provider has since applied to the Care Quality Commission to remove the location Oakhurst from their registration and close the home.

Staff had received limited supervision and leadership since the last registered manager had left the service. The registered provider had not had regular input into the service or continued to monitor the service in the absence of a registered manager.

The systems to monitor the quality of the service were not effective. We found a number of concerns during our inspection. For example, people were not safe and were not protected from the risks of harm. People's medicines were not managed well and recruitment procedures were not robust. There was insufficient information available for staff to safely evacuate people from the building in the case of emergency. Care plans were large inconsistent documents that did not provide staff with sufficient information on how to meet people's needs. Nutritional needs were not well monitored. There was little evidence that people were involved in completing their care plans or were asked for their views on the service. Staff did not receive regular supervision to ensure their competence was maintained and staff did not always speak about people in a manner that maintained their dignity.

Some audits were seen but they were not consistent and where issues had been identified they had not been addressed. For example, care plans had been audited on 3 March 2015 and had identified there was limited involvement with people. However, there was no evidence a plan was in place to address this. An infection control audit had been started on 3 March 2015 but had not been completed.

This was a breach of regulation 17(1)(2)(a)(b)(c)(e)(f) 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

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 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 **People were not protected from improper treatment. Regulation 13(1).**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **Medicines were not managed in a safe manner. Regulation 12(2)(g).**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed **Recruitment procedures were not robust. Regulation 19(3)(a).**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care **Care was not designed to ensure it met people's needs. Regulation 9(3)(a)(b).**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing **Staff did not receive regular supervision to ensure their on-going competence. Regulation 18(2)(a).**

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 Care and treatment was not provided in a safe manner. Risk assessments to ensure people's health and safety had not been followed. Regulation 12(1)(2)(b).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance There was no effective system in place to assess and monitor the service. Regulation 17(1)(2)(a)(b)(c)(e)(f).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment The environment did not meet the needs of people living with dementia. Regulation 15(1)(c).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance Contemporaneous records were not maintained for each person. Regulation 17(2)(c).