Laudcare Limited

Oaktree Care Home

Inspection report

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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

This inspection took place on 24, 26, 27 February 2015 and was unannounced. At the previous inspection of 10 and 11 September 2014 we found there were two breaches of legal requirements. These were related to staffing levels and care documentation.

Oaktree Care Home is registered to provide personal care and nursing care for up to 78 people. The service was divided over two separate floors. The ground floor was for those who required nursing care and the upper floor was dedicated to those people living with dementia. On the visit of 24 February there were 27 people living on the upper floor and 35 on the nursing floor.

There was not a registered manager in post. 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

Summary of findings

the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. A manager had been appointed in December 2014 and they had applied to register with the Commission.

It was evident throughout the inspection there was a significant divide between the safety and quality of services provided on the nursing floor and the upper floor.

There had been a reduction in staffing levels on the upper floor between 2 and 24 February. On 24 February we found people's safety had been put at risk which had resulted in accidents, incidents and injury. Two people had been assessed as requiring one to one support due to an increase in falls but the staffing levels were unable to support this. People were not receiving personalised care and their dignity and respect had been neglected. Routines had been compromised including mealtimes where people who required assistance were left unsupported with food and drink. Staff were unable to effectively support two people whose health had significantly deteriorated that day. All staff working on the upper floor were "tired, frustrated and demoralised".

The manager contacted the area manager on the evening of 24 February 2015 who agreed to increase staffing to the original levels prior to 2 February 2015. On our return visit of 26 February things had improved. The number of people had decreased from 27 to 25. It was a quieter day and things were calmer and more settled. There were no emergencies or significant events during the day. Staff morale was more positive and they had recommenced their previous routines and ways of working. In addition to this the local authority were urgently reviewing funding for the two people who were prone to falling so they could have one to one support from additional staff members.

Because the staffing levels had increased and the risks had reduced we continued the visit of 26 February gathering evidence about other areas we needed to look at. People living on the nursing floor were safe and there were enough staff to meet people's needs. They confirmed care and support was personalised. Choice and personal preferences were encouraged and supported by staff. People on the nursing floor told us they were listened to. Mealtimes were "pleasant and enjoyable" and people had sufficient amounts of food and drinks. People on the nursing floor told us they were "happy" with the care they received and had "no complaints". Staff were equally "happy" and "enjoyed" their work.

Staff were knowledgeable in safeguarding procedures and knew how to identify and report any abuse. Suitable recruitment procedures ensured staff were safe to work in the service. The service had been closely monitored through an external multi-agency approach over the last year due to repeated ongoing safeguarding's. This was led by the local authority safeguarding team. Other participants included, the Care Quality Commission, GP's, community nurses, social workers and local authority commissioners. The commissioners were responsible for funding people who lived in the service.

People living with dementia on the upper floor were not always receiving their medicines at the prescribed time. Nurses on both floors were not following medicine policies and procedures.

Staff received training so they had the knowledge and skills they needed to carry out their roles effectively. They felt supported on a day to day basis by the manager, unit managers, nurses and colleagues. Formal supervisions were underway for this year and dates for appraisals had been arranged.

People and relatives said staff were "caring and thoughtful" and there had been improvements following the previous inspection. There were positive interactions between people and staff. Staff had a good awareness of individuals' needs and treated people in a warm and sensitive manner. However we did see some poor practice on the upper floor where people's dignity had not been respected at mealtimes and some people looked unkempt.

On our final visit of 27 February we met with the manager and area manager. We were shown email correspondence and attachments which evidenced that the manager had made an error when completing the tool that determined staffing levels. Because they had omitted to complete sections of the tool it had indicated the levels should be reduced. This meant during the period of 2 February to 24 February there were insufficient staff levels to safeguard the health, safety and welfare of people on the upper floor. However, suitable steps had been taken on 24 February to address this. The

Summary of findings

providers quality assurance procedures failed to identify that the staffing level tool had been completed incorrectly. This raised concerns about the effectiveness of the provider's quality assurance systems.

We found seven breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We completed this inspection at a time when the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009 were in force. However, the regulations changed on 1 April 2015; therefore this is what we have reported on. You can see what action we told the provider to take at the back of the full version of this 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.

People on the upper floor were not supported by enough staff in order to keep them safe.

People's medicines were not being managed safely.

People received care from staff who were trained in safeguarding and recognised abuse.

People were protected through appropriate recruitment procedures.

Is the service effective?

Requires Improvement

The service was not always effective.

People on the upper floor were not provided with sufficient food and drink and choice was not always promoted and supported.

Staff received training and felt supported by the manager and unit managers.

People's rights were protected because staff acted in accordance with the Mental Capacity Act 2005.

The service recognised the importance of seeking expertise from community health and social care professionals so people's health and wellbeing was promoted and protected.

Is the service caring?

Requires Improvement

The service was caring but improvements were required.

People were not always treated with dignity and respect.

Staff were caring and kind and they wanted people to experience good quality care.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People did not always receive care and support that was personalised.

People living with dementia were not provided with enough activity and stimulation. They were left alone for long periods of time.

People were listened to and staff supported them if they had any concerns or were unhappy.

Is the service well-led?

Inadequate

The service was not well led.

Summary of findings

People did not receive the highest quality care and some had been placed at risk because of management decisions to reduce staffing levels.

Where concerns had been raised, these had been ignored or not taken seriously.

The service had significant shortfalls and there were four breaches of regulations.

Oaktree 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 24, 26 and 27 February 2015. The inspection was undertaken by three adult social care inspectors. Prior to the inspection we looked at information about the service including notifications and any other information received by other agencies. Notifications are information about specific important events the service is legally required to report to us.

We conducted a Short Observational Framework for Inspection (SOFI). SOFI provides a framework for directly observing and reporting on the quality of care experienced by people who cannot describe this for themselves.

During our visit we met and spoke with 11 people living in the service and three relatives. We spent time with the area manager, manager, two unit managers and three nurses. We spoke with eight care staff and two activity coordinators.

We looked at 12 people's care documentation, together with other records relating to their care and the running of the service. This included five staff employment records, policies and procedures, audits, quality assurance reports and minutes of meetings.

Inadequate

Is the service safe?

Our findings

There had been 51 safeguarding alerts raised in the last year with the local authority safeguarding team. Twenty-nine of these had been screened out of safeguarding where it had been assessed that people had not come to harm. The remainder were investigated by the local authority and discussed at meetings with the manager and area manager. We attended some of the meetings. Where safeguarding concerns had been upheld we heard from the area manager and manager about where improvements were made to help prevent a reoccurrence of such incidents. Some of the safeguarding concerns that were upheld included those where a number of people had sustained serious injuries including lacerations and scalds.

Staff referred to incidents where people who required a specific level of support had not received this and had come to harm. Three staff members referred to events that had happened during an 8am-2pm shift on 19 February 2015. One person who should have received one to one supervision fell whilst not being watched and sustained a laceration above their eye. This person was not being provided with the one to one support that they had been assessed as needing. A second person fell whilst walking alone when they should have been supported by one carer following recent orthopaedic surgery.

This was a breach of regulation 11 of the Health and Social care Act 2008 (Regulated Activities) Regulation 2010, (now regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014).

The provider used an electronic tool to determine staffing levels. The tool required information about the dependency levels of people's needs, the environment and if anyone required one to one care.

Prior to our inspection we received information of concern about a recent reduction in staffing levels on the upper floor. We were told the reduction in staffing levels meant that people were not safe. During our visits staff members spoke with us about the level of care and support people required on the upper floor. They confirmed the reduction in staffing had placed people's safety at risk.

On 24 February there was one nurse and five care staff on duty between 8 - 2pm. An additional nurse was on duty to carry out management duties. However, because of the high level of care and support people required that day, they assisted on the shifts to support the nurse in charge and care staff. The shift was chaotic and throughout the day people were often left unattended when they required support.

One person had become acutely unwell and required close monitoring. The health of another person had deteriorated rapidly during the morning. These people required regular monitoring and support but there were not enough staff to do this. Two staff members were periodically trying to stay with the people who were unwell. However this left three staff to attend to the remaining 25 people. These people required support with all personal care, continence care, moving and handling and eating and drinking.

The nurses were unable to assist the care staff because they were carrying out their own duties. This included a medicine round and assisting two GP's with their visits. They also called paramedics twice for the two people who were unwell and facilitated their arrival. As a result of the paramedic visits the nurses had to organise a hospital admission for one person. Following the paramedics assessment it was agreed the other person would remain at the service for end of life care. The nurses proceeded to contact family members and obtain medicines from the pharmacist to make the person pain free and comfortable. One staff member had been asked to "keep an eye" on the person who was receiving end of life care. They told us, "I feel terrible; one of us should be sat with the person holding their hand and reassuring them. I am just about managing to pop in and out".

On the evening of 24 February 2015 we saw a person who had been showing signs of anxiousness and anxiety fell twice in a 20 minute period. Although two staff members had attended to this person for periods of time they had others to assist and the person had been left unsupervised.

Other observations that evening included verbal altercations between two people who were sitting together and becoming abusive towards each other. Two other people were anxious and shouting out. There were not enough staff to de-escalate the situation or offer reassurance and comfort to these people.

We asked staff throughout the shift how they were managing. Comments included, "We are doing the best we can but it's not enough", "We will have to provide the basics

this morning, it's gone 11am and some people have not had breakfast yet, they must be hungry" and "When we have emergencies like today it all goes wrong, there are not enough of us to go around".

Reduced staffing levels had impacted on when people received meals and drinks. Staff referred to a recent shift where breakfast had not finished until 11.15am and lunch was due to be served at 12.30pm. This meant that some people only had a one hour fifteen minute break between breakfast and lunch. Staff told us people did not receive a drink from the morning coffee round because they did not have the time to do this. Lunch was 20 minutes late and finished at 2.45pm. The afternoon tea round was due to start at 3pm.

Even though it was identified during the inspection that the staffing tool had been incorrectly completed by the manager we could not be satisfied the tool was effective. The manager did not have contingency plans to consider and take into account unforeseen circumstances or emergencies. One staff member said, "We might have empty beds but people are very much end stage dementia with very high needs. Whatever tool they are using it's not working". Where staff had raised serious, genuine concerns about the impact of reduced staffing levels they were not listened to.

This was a breach of regulation 22 of the Health and Social care Act 2008 (Regulated Activities) Regulation 2010. (now regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014).

Records and practices demonstrated medicines were not managed safely. The provider's policies and procedures were not being followed. Some medicines had not been checked and signed for when received. This meant it was not possible to complete an accurate stock check. We checked stock balance for those medicines that had been recorded on receipt into the service and administered. They had incorrect amounts of stock remaining.

Some medicines were prescribed for people "as required or when necessary". These are referred to as PRN medicines and include those that treat and relieve pain, anxiety and constipation. Not everyone had a PRN protocol in place. A protocol is needed for PRN medicine because, unlike medicines given on a regular daily basis, staff need to know when a PRN medicine should be given. The protocol should provide additional information about the medicine to help staff understand when and how much to give. We also saw that where variable doses were prescribed the amount given was not always recorded. We could not be satisfied there was safe management and administration of PRN medicines.

The nurses on the upper floor told us the medicine round was taking up to two hours in the morning. They said this was attributed to various factors. People living with dementia required a degree of time when taking medicines because they were confused. They required patience and reassurance and the nurse stayed with the person until all the medicines had been swallowed. Some people were at risk of choking and nurses administered medicines slowly. Others required assistance to sit up. Sometimes the nurse needed another member of staff to help them do this. Staff were not always available because they were busy in people's rooms providing personal care, continence care and serving breakfasts. People on the upper floor were not receiving their medicines at the prescribed time. We could not be satisfied there was a safe time period between doses as prescribed.

This was a breach of regulation 13 of the Health and Social care Act 2008 (Regulated Activities) Regulation 2010. (now regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014).

The service was proactive in raising alerts if they suspected abuse had occurred or people had come to harm. The manager and staff had a good level of understanding about what constituted abuse and the processes to follow in order to safeguard people. Information was available about who to contact should they suspect that abuse had occurred. Staff gave us examples of where they would raise a safeguarding alert and the relevant people to contact including the local authority, the Care Quality Commission and the police.

Risk assessments were in place for maintaining skin integrity, safe moving and handling, monitoring nutritional needs and continence. Assessments provided staff with the level of risk and gave staff clear instructions of any care or intervention that may be required. Examples of intervention the service had taken included a referral for specialist advice from a dietician and supplying specialised equipment such as pressure relieving aids.

Staff on the nursing floor told us the staffing levels were safe. The atmosphere was calm and relaxed. People felt

Inadequate

Is the service safe?

they were safe and in "good hands". One person told us, "The staff are lovely, and yes I do feel safe and comfortable here". Another person spoke about a recent fall and how this had not happened to them before. They said, "I didn't wait long before they came to help me up. They used a hoist, which was a new experience for me, I felt in safe hands". The accident had been fully reported and documented, and the person had been reviewed by the GP.

Recruitment and selection processes helped protect people. Checks had been completed before staff commenced employment, including those with the Disclosure and Barring Service (DBS). The DBS helped employers make safer recruitment decisions by providing information if a worker had a criminal record and whether they were previously barred from working with adults.

Requires Improvement

Is the service effective?

Our findings

There were not enough staff on the upper floor at mealtimes. The staffing levels had not taken into account the level of care and support people required. We saw written evidence that people had been assessed to determine the level of assistance they needed at mealtimes. Eight people required full assistance, 14 required regular prompting and assistance, and four were independent.

On our visit of 24 February we conducted a SOFI on the upper floor. There were 13 people in the dining room and we observed four of those people for 45 minutes during the lunchtime meal. Two staff members were in the dining room to assist all 13 people. On one table three people required full assistance with their meals and drinks. Two people were assisted first whilst the third person watched and waited for 30 minutes. There was no interaction before their meal was brought to them and they were assisted to eat.

Another person kept spilling food into their lap and tried to retrieve the food with their fingers. At no time did any member of staff assist this person. Finally they got up from the table and walked away. Staff did not intervene or check this person when they left. We did not see them being offered any drinks or puddings and the remains of their meal was eventually taken away and placed with a pile of other dirty plates. This meant it was impossible to assess how much food this person had eaten.

Three remaining staff members were making every effort to take meals to people in their rooms in a timely manner and assist them with eating and drinking. In addition to this a person's health deteriorated and the paramedics had been called. One staff member was asked to sit with them to observe and provide reassurance. This left two staff members to continue with lunches for 14 people.

Between 1.15pm and 2pm three people were sitting in their rooms on the upper floor with plates of food in front of them, untouched and cold. Two of them had fallen asleep. They had attempted to eat their meals, however their plates did not have guards on them and the food had slipped off the plates onto their tables and laps.

At tea time we saw further examples where people were not sufficiently supported to eat and drink. Food debris had fallen on their tables, laps and the floor. One person was able to load food on to their spoon but each time they moved the spoon towards their mouth the food fell from the spoon. We could not be satisfied that people living on the upper floor had the required support in order to ensure they had enough to eat and drink.

People's choice at mealtimes was not always sought or respected on the upper floor. One tea time we saw people were served with the same mixed variety of sandwiches and they were not offered a choice. One person had only eaten one of their four sandwiches and told us, "I don't like ham, they keep giving me ham and I don't like it". The unit manager overheard this and asked the person what sandwiches they would like. They were served egg sandwiches and ate them all. The other people were left with the variety they were given.

Staff monitored and recorded food and drink for those people who had been identified at risk. The nurses were meant to countersign the records to confirm they had looked at people's intake. This was so they could highlight any concerns and take any necessary action. This was not always happening and signatures were missing.

This was a breach of regulation 14 of the Health and Social care Act 2008 (Regulated Activities) Regulation 2010. (now regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014).

People on the nursing floor told us they had enough to eat and drink. Most people were independent and required minimal support. The lunch time appeared calm and sociable. One person told us, "The food is lovely; I had egg and chips today". This was not one of the two main choices available, but the person told us they often had something different to what was on the menu.

There was a varied programme of training every year in addition to the mandatory updates staff received. Staff told us they enjoyed training and having the knowledge and skills to carry out their roles effectively. A training spreadsheet alerted staff if any training updates were required and provided them with dates that training had been arranged for.

All staff were in the process of completing a distance learning course in safeguarding and dignity. Training updates had been arranged in promoting person centred care for February. New staff were waiting for courses in

Is the service effective?

dementia awareness and training for supporting people who become distressed. This was to help staff with techniques to support people when they became anxious or when certain behaviours escalated.

Some training was completed through E learning. This is where staff access and complete learning on a computer. The manager was in the process of looking at ways of ensuring it was valuable and effective for staff by asking for their feedback. It was recognised staff needed to share their level of understanding and how they would implement this to enhance their roles and the care and support people received.

Some care staff had completed nationally recognised qualifications in health and social care and others were in the process of completing this. The provider had an extensive list of training courses staff could access either internally or externally.

Overall staff felt they were supported on a daily basis by the manager, unit managers and nurses. However staff we spoke with on the upper floor had not felt supported by the manager following the recent reduction in staffing levels. Comments included, "I am confident to speak with the unit manager quite freely and they do all they can to support me", "The nurses are very busy but they always make time to advise me when I have a question" and "The manager and unit managers are all very good, they do everything they can but I appreciate their hands are tied with some things".

The manager spoke with us about new initiatives implemented around supporting staff. Clinical supervisions for nurses included group discussions around medicine practice and wound care management. Practical supervision sessions were for all staff and helped support effective completion of food and drink intake charts, daily records and maintaining the monitoring of people's weights. These were formally recorded and evidenced the discussions that had taken place and where extra training or support may be required.

Supervisions supported staff to discuss what was going well and where things could improve, they discussed individuals they cared for and any professional development and training they would like to explore. Staff were in the process of receiving their annual appraisal.

Care staff had a basic level of understanding about the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS). The MCA provides a legal framework for those acting on behalf of people who lack capacity to make their own decisions. The DoLS provide a legal framework that allows a person who lacks capacity to be deprived of their liberty if done in the least restrictive way and it is in their best interests to do so. Staff understood its principles and how to implement this within the service. They spoke about the meaning of best interest decisions and gave examples where this may apply, for example the use of bed rails.

The manager had submitted DoLS applications for those people who had been assessed as not having capacity. This was to ensure that if there were restrictions on their freedom and liberty, they would receive an assessment by a professional who was trained to determine whether the restriction was needed and in their best interest.

Assessments were used to determine if people were at risk of malnutrition or obesity. They provided guidelines about specific support people would require if they were at risk. This included seeking expert advice from GP's, community dieticians and speech and language therapists for those people who had difficulty swallowing. People's weight was monitored and the frequency increased for those who were at risk. Some people were recovering from chest infections. Their appetite had decreased and they were being weighed weekly until this improved. Staff were following instructions in care plans. This included adding a thickener to drinks for those people whose swallow was compromised and were at risk of choking.

Staff ensured people had prompt and effective access to health care including preventative screening and vaccinations, routine checks, GP call outs and access to emergency services. Staff recognised the importance of seeking expertise from community health professionals so that people's health and wellbeing was promoted and protected. They had been supported by the community nurses, physiotherapists and specialist nurses in enteral feeding. Enteral feeding refers to the delivery of a nutritionally complete feed which goes directly into the stomach.

Requires Improvement

Is the service caring?

Our findings

People who lived on the upper floor were not always treated with dignity and respect. On the first day of the inspection people were not offered protective clothing at mealtimes and clothes were stained with food and drink. Mealtimes were not always respectful and conducive to a pleasant dining experience. During one tea time people were eating in a communal lounge and a domestic was vacuuming around them. In one of the dining rooms music was playing loudly from a local radio station and this did not create a relaxed mealtime experience. The music was not age-appropriate.

People looked unkempt, clothes were creased, some men had not been shaved, and their hair and teeth appeared dirty. People were not asked if they wanted to wash their hands before or after their meals. They had dried food on their faces. Staff agreed "standards had slipped" and "people were only receiving basic hygiene". One member of staff said, "Some people have not had their hair washed for a few weeks because they have not had a bath or shower".

This was a breach of regulation 17 of the Health and Social care Act 2008 (Regulated Activities) Regulation 2010. (now regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014).

People and relatives said staff were "kind and caring". Comments included, "They are lovely", "I'm overwhelmed, the staff are so kind", "We're really pleased with how well our relative has settled in" and "They are a lovely bunch and they do the best they can".

During one of our visits a community nurse had arrived to meet with a person and their family. This was to review their care needs and make sure these were being met by the service. When they had finished the review they met with the manager to feedback about the meeting. The review was positive the family said "staff were caring and loving towards residents" and they were "happy and satisfied with the quality of care".

Conversations with all staff demonstrated their determination and commitment to the people they supported. Staff who worked on the upper floor were genuinely frustrated and disappointed in the standard of care they had been providing over recent weeks.

We saw examples where people were treated with dignity and care. During one lunch time on the upper floor we saw two people who could not eat or drink independently. They were being assisted with patience and sensitivity. Assistance was provided at a gentle pace and staff sat at the same level as the person. Staff explained to people what they were eating, they engaged with the person they were assisting throughout the mealtime and offered drinks.

Staff were friendly, kind and discreet when providing care and support. One person on the upper floor was prone to falls. We saw them slip from their chair when they attempted to stand and they were very anxious and confused. Two members of staff also witnessed this incident. They transferred the person from the floor onto the chair using a hoist. The procedure was dignified and staff constantly reassured them about what was going to happen next and that they would remain safe. They made sure the person felt comfortable before they left the room.

Requires Improvement

Is the service responsive?

Our findings

Pre-admission assessments took place for those people who were considering moving into the service. The information gathered was not always complete and did not evidence a thorough assessment. It did not enable the manager and prospective "resident" to make a decision as to whether the service was suitable and that their needs could be met. The manager acknowledged improvements were required.

The quality, content and accuracy of care documentation varied for each person on both floors. Although some care plans were well written, detailed and up to date, others were not. They did not reflect that individual needs, wishes and preferences were taken into account. Staff confirmed not everyone had been involved or consulted about how they wished to be supported and cared for.

People on the upper floor were not always at the centre of the care they received because staff focused on the task rather than the individual. They were not always receiving care that was personalised. One staff member said, "People are not receiving the care they need and we have been cutting corners". Staff said they had not been providing baths or showers to everyone because it "took too long".

One relative had written to us about their recent disappointment when they had asked a staff member if they would wash their relatives back, to which they replied they were "too busy". One staff member described a recent shift where it was "so busy" one person was still in bed and had not had a wash and it was 2pm. They had been served breakfast and lunch in bed. We were told this was not the person's preference and their choices had not been respected that day.

Although there was information about people's physical and health needs staff had not considered people's emotional and social well-being. People's life experiences, interests and hobbies were not always sought. There was not a consistent approach to monitoring, evaluating and updating care plans so they did not accurately reflect current needs and the care people were receiving.

This was a breach of regulation 9 of the Health and Social care Act 2008 (Regulated Activities) Regulation 2010. (now regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014).

On the upper floor there was evidence to demonstrate staff knew people's needs. One person was being moved by using a hoist and sling. We asked staff how they knew what hoist and sling to use. They told us that this information was documented in care records and the size of sling had recently changed following re-assessment. We checked the care records and this information was accurately documented and reflected what we were told by the staff.

People on the nursing floor told us they were consulted about how they wished to be cared for and supported. Routines were "fairly flexible" and they expected there to be "routines around mealtimes and tea and coffee rounds". People organised how they spent their day, whether this was in the privacy of their own room, joining other people for lunch, taking part in an activity, receiving visitors or going out.

There was little in the way of stimulation for those people living with dementia. Apart from the group activities provided, people on the upper floor had very little to occupy themselves with. Throughout our visits there were groups of people sitting in communal lounges, unsupervised with nothing to do. A Four Seasons representative carried out an audit on 9 January 2015 and wrote, "In the upstairs section of the home, I observed extremely little by way of activities with the residents, who were simply sat in the lounge, unoccupied, for long periods".

The service had recently recruited and increased social activity provision to five hours per day on each floor. There were three activities co-ordinators and they were a newly established group. The manager had arranged a meeting in March to discuss plans for future programmes of group activities and one to one sessions particularly for those people living with dementia.

People on the nursing floor were satisfied with the activities provided. During our visits they were enjoying private time in their rooms, reading, listening to music, watching television and receiving visitors. Other people chose to spend time in communal rooms taking part in an activity or enjoying other people's company. Musical entertainers visited the home and other people from the community provided services for example musical exercise classes.

People on the nursing floor said they knew how to complain and express any concerns. Comments included,

Requires Improvement

Is the service responsive?

"If I am unhappy about anything I will speak with the nurse", "My family are very good at sorting things out for me" and "If I have complained it's been about small things that have been easily rectified".

Staff acknowledged people living on the upper floor were not always able to express their concerns because they had dementia. Staff said they knew if people were unhappy with something because of changes in behaviours and they would support them in order to relieve any anxiety or concern. In addition to this, relatives spoke on their behalf and represented their loved ones and raised any issues as formal complaints.

There had been a decrease in formal complaints in recent months. The manager and unit managers encouraged people and their families to express any concerns or anxieties and dealt with these promptly. They felt this approach prevented concerns escalating to formal complaints and relieved any anxiety that people may be feeling.

We recommend that the service seek advice and guidance from a reputable source, about providing meaningful activities and stimulation for those people living with dementia.

Inadequate

Is the service well-led?

Our findings

Evidence clearly demonstrated all staff working within the service meant well and cared about people. However the recent error when completing the staffing tool, and the failure to take the appropriate action when staff had told the manager people were not safe raised serious concerns. People had been put at risk and the quality of care compromised for people that lived on the upper floor. The area manager agreed the managers training in completing the staffing tool had not been effective and the submissions should have been checked.

The area manager told us the tool should not be the definitive guide to staffing levels. However this message had not been shared with the manager. When the manager had asked for the staffing levels to increase the request had been refused based of the results of the staffing tool. This not only raises concerns around transparency within the organisation but also the quality of the manager's induction and supervision.

Accident and incident documentation contained a good level of detail including the lead up to events, what had happened and what action had been taken. Any injuries to people were recorded on body maps. However there was little evidence of learning from incidents that took place. There had been no analysis of accidents or incidents to identify triggers or trends. This in turn meant that preventative actions were not considered. This had been identified at an audit completed in January 2015 by a Four Seasons representative. The manager was unaware that this was an organisation requirement which again raises questions about the effectiveness of their induction.

This was a breach of regulation 10 of the Health and Social care Act 2008 (Regulated Activities) Regulation 2010. (now regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014).

Although the manager was aware when notifications of events had to be sent to us there had been a number of occasions when this had not happened. When we had received notifications, they had not been sent in a timely manner and they didn't always contain enough detail. We had to remind the manager they had not notified us of significant recent incidents that had come to our attention during our inspection.

This is a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

Some of the practices promoted by management raised concerns about the day to day culture in the service particularly around influencing staff attitude and institutional approach. In the main dining room on the upper floor there was a large white board. This displayed people's room numbers and what level of assistance people required at mealtimes. A box was provided next to each room number to allow staff to tick off when the meal was complete. This was a shared area and demonstrated a task centred approach to meeting people's care needs and indicated a culture where people were regarded as 'tasks' to be completed. The manager had not noticed the potential of this until our discussion. The information was removed by the manager.

Notices were on display around the upper floor which stated that "violence would not be tolerated against staff". Such notices were not viewed in other areas of the service. We asked the manager to explain the intention of the notice and its target audience. They told us they recently had some difficulties managing abusive and threatening behaviour from some relatives towards staff. We highlighted to the manager they should have policies and procedures to manage such incidents and should seek other alternatives to relay their message to those concerned. This could support a culture whereby visitors view people as a threat to staff and create a negative impression of that area of the service. The manager removed the notices.

Management within the service had been inconsistent in the previous 18 months. The new manager commenced in September 2014 and they understood the challenges the service faced when they were appointed. The manager told us they were committed to making improvements. The manager was not a nurse and was being supported by two unit managers who were nurses. Part of their role was to support the manager in driving improvements in the home. It was evident during our discussions they were working well together.

They had assessed and prioritised things that required improvement in order to move the service forward. This included staff recruitment, revised routines, and training updates, raising staff morale, promoting team work and improving communication through regular meetings. People, relatives and staff told us things had improved and

Inadequate

Is the service well-led?

they were positive about having a consistent management team. Comments included, “It’s good to see the manager around the home”, “The unit managers are very approachable and capable. They also do nursing shifts so they know my relative very well”, “Very slowly we have seen some positive improvements and staff retention has improved because of this” and “It’s a nicer place to work we want to be proud about the home again”.

We recommend that the service seek advice and guidance from a reputable source, and undertake a high level review of the management, leadership and culture within the home.

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 Treatment of disease, disorder or injury	Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010 Safeguarding people who use services from abuse **People were not safeguarded against the risk of abuse because reasonable steps were not taken to identify the possibility of abuse and prevent it before it occurs.** **Regulation 11 (1) (a)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines **People were not protected against the risks of the unsafe management of medicines.** **Regulation 13**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 14 HSCA 2008 (Regulated Activities) Regulations 2010 Meeting nutritional needs **People were not protected from the risks of malnutrition and dehydration.** **Regulation 14 (1) (a) (c)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010 Respecting and involving people who use services **People were not always treated with dignity and respect.**

This section is primarily information for the provider

Action we have told the provider to take

Regulation 17 (1) (a) (2) (a)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services **Planning and delivery of care did not meet people's individual needs.** **Regulation 9 (1) (b) (I)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service provision **The systems in place for monitoring the service were insufficient to ensure people's safety and wellbeing.** **Regulation 10 (1)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents **Important events that affect people's welfare, health and safety are not reported so that where needed, action can be taken.** **Regulation 18 (1) (2) (a) (ii)**

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 Treatment of disease, disorder or injury	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing There were insufficient numbers of staff to ensure people's safety and wellbeing. Regulation 22

The enforcement action we took:
A warning notice was served and the breach was rectified during the inspection