Mr Kevin Hall

The Oaks Private Residential Home

Inspection report

Oak Avenue
Hindley Green
Wigan
Greater Manchester
WN2 4LZ

Tel: 01942521485

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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**

Summary of findings

Overall summary

The Oaks is a two storey purpose built care home in Hindley Green, Wigan. The home is registered to provide personal care and support and diagnostic and screening procedures for up to 31 adults. The registered manager was not aware that registration for The Oaks was for two regulated activities. The registered manager needs to apply for a variation to remove the regulated activity diagnostic and screening as this is not provided at the service.

This was an unannounced inspection that took place on 12 April 2016. There were 25 people using the service at the time of the inspection. We last inspected the home on 24 July 2014 and found the service was meeting four of the five regulations that we reviewed. One of the regulations relating to cleanliness and infection control was not met. We revisited the home on 02 March 2015 and found this regulation had now been met.

At the inspection on 12 April 2016 we found ten breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These breaches related to: safe care and treatment, person centred care, safeguarding service users from abuse and improper treatment, privacy and dignity, meeting nutritional and hydration needs, premises and equipment, complaints, good governance and staffing

There was a registered manager in post at the time of the 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 and associated Regulations about how the service is run.

On arrival at the home, the senior in charge to the shift was unsure of the numbers of people living in the home.

Staff spoken with did not have a clear understanding of the whistle-blowing procedures and were unsure of what to do if they if they suspected any abuse or neglect of people who used the service.

We found that people were not cared for by sufficient numbers of suitably skilled and experienced staff. Staff had not undertaken up to date training and support to enable them to do their job effectively and care for people safely.

We observed that people's dignity was not always respected.

We found the systems for managing medicines were unsafe and that people were not receiving their medicines in a timely manner as prescribed. For some people the risk identified placed them at risk of significant harm.

The care records were not person- centred and did not contain sufficient information to guide staff on the

care and support that people required. We found gaps in the care files where reviews should have been completed.

The service was not meeting the requirements of the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS). People were not supported to make choices and decisions.

Systems used to monitor training and the delivery of supervisions were out of date. The training matrix showed that there were gaps in mandatory training. New staff had not completed a staff induction programme as required.

Staffing levels were not satisfactory to meet the needs and preferences of people who used the service. Staffing levels were defined by the number of people living in the home and not by the levels of dependency.

People who used the service were not provided with adequate nutrition and hydration to meet their needs. The chef had no menus to work with and meals were planned around what food was available in home. The timing of meals should be reviewed as all the people who used the service were offered breakfast at 10.00. This meant that people who were early risers had to wait for their breakfast.

We saw that the activities were limited and the activity coordinator was deployed to other caring tasks.

Not all areas of the home were clean and well maintained. We observed areas of poor infection control and a lack staff hygiene which could increase the risk of cross infection to people who used the service.

Systems were not in place to effectively assess and monitor the quality of the service provided.

Relatives spoken with were happy with the care and support their relatives received.

We look at staff recruitment files and found these to be satisfactory. Appropriate checks were in place to help ensure that staff were suitable to work with vulnerable people.

The overall rating for this provider is 'Inadequate'. This means that it has been 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.

We are considering our enforcement actions in relation to the regulatory breaches identified. We will report further when any enforcement action is concluded.

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 were not protected from the use of unsafe medicines.

Records showed that recruitment checks had been carried out to help ensure that suitable staff were recruited to protect people who lived at the home.

People were not safe as equipment was not being used effectively.

Not all staff had undertaken training in the protection of vulnerable adults and they were unaware of the term whistle-blowing and what this meant.

People were not protected by the prevention and control of infection.

Is the service effective?

Inadequate

The service was not effective

The service was mainly caring for people living with dementia. There was no evidence of signage to help with orientation around the home. There was a lack of colour to distinguish certain areas such and bathrooms and bedrooms

People who used the service were not provided with adequate nutrition and hydration. There was a lack of finger food/ snacks for people, which is important for people living with dementia and people's dietary needs were not adhered to.

The service was not meeting the requirements of the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS). People were not supported to make choices and decisions and some people were unlawfully deprived of their liberty.

Staff training and staff supervisions and staff appraisals were significantly overdue.

Is the service caring?

Requires Improvement

Not all aspects of the service were caring.

People told us that staff were kind and caring.

On one occasion staff did not clearly explain what they were doing when supporting a person using the hoist. This person's dignity was also compromised by staff.

The staff had a limited understanding of the care and support that people required and did not actively promote people's independence.

People were not involved with day to day decisions about their care.

Is the service responsive?

Inadequate

The service was not responsive

The care records did not contain sufficient information to guide staff on the care and support people required. The care plans had not been regularly reviewed and updated.

People did not receive personalised care that was responsive to their needs.

There was a lack of meaningful activities throughout the home that reflected preferences and interests.

In the event of a person being transferred to hospital the systems were slow and could have resulted in the event of a serious emergency that the emergency services would not be able wait for the necessary paperwork.

The complaints procedure was not prominently displayed to advise people on how to raise any concerns or complaints.

Residents' and relatives' meeting were not held and feedback from stakeholders was not sought in attempt to improve the service.

Is the service well-led?

Inadequate

The service was not well led

Not all members of staff thought they were supported by the registered manager. The registered manager had failed to ensure

that staff working at the home were suitably skilled to carry out their job effectively.

The registered manager had a lack of understanding of systems and processes required to meet the regulations and was apathetic when failings were discussed

The system for monitoring and assessing the quality of the service was ineffective. There were a small number of audit checks in place; however there was no analysis or follow-up actions in place.

The Oaks Private Residential 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 checked 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 12 April 2016 and was unannounced. The inspection team comprised of two adult social care inspectors from the Care Quality Commission (CQC), a specialist practitioner advisor (SPA) who was a registered general nurse and an expert by expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of services.

Before the inspection we reviewed the previous inspection reports and notifications we had received from the service.

During this inspection we spoke with seven people who used the service, five visitors, five staff, the chef, the deputy manager and the registered manager. We did this to gain their views about the services provided. We looked around most areas of the home, observed how staff cared for and supported people, looked at five care records, medication, three staff recruitment files, training and records around the management of the home.

Inadequate

Is the service safe?

Our findings

During the inspection we spoke with seven people who used the service. People told us they felt safe living at the home. One person said, "I feel safe from harm or bullying from staff and other people, definitely I feel safe". Another told us, "I would go to the activities coordinator or the manager to sort my problems out". A visitor spoken with said, "I have never seen any aggression here."

We found that medicines were not managed safely. Records about the administration of medicines were poor. We saw there were an unacceptable number of gaps on the Medication Administration Record sheet (MARs) so it was impossible to tell if medicines had been given at all. There were also missing signatures from pages in the controlled drugs register.

We observed secondary dispensing taking place on 12 April 2016. The senior carer prepared the medication and gave it to the deputy manager to administer. The senior carer then signed that they had administered the medication, which they had not done. Secondary dispensing is a known risky procedure as the person signing for the medicine did not know if the medicines had actually been administered.

We saw the senior carer coming on to the first floor with a pot of medicines. When asked if this had been signed for downstairs on the MAR the senior carer said it had been signed before being given. This was witnessed on more than one occasion, that the senior carer was signing MARs before administering medicines. This meant there was not an accurate record to show that all medication had been taken by the correct person.

We saw that medicines were not always locked away during medication rounds. On the day of our inspection visit we found the medicines trolley left unattended five times and on one occasion the senior carer left the room. This meant people who used the service could have accessed the medicines.

We found there was a lack of information available to guide staff where to apply people's creams to them. We found carers failed to make any records when they applied creams to show people had their prescribed creams applied properly. There were no records to indicate they had applied the cream and where they had applied it and if the cream had been applied properly or at all.

We saw that the manufacturers' directions were not followed. Medicines, including antibiotics, which should have been given before food were given with food, which means they may not work properly.

For one person, eye drops were administered in the dining area and the senior carer applied this without washing their hands or the use of disposable gloves. We observed the medicine pots were piled up on the trolley, these fell off the trolley on to the floor where they picked up and continued to be used.

Two people were prescribed a thickening agent to add to their drinks to make sure they could have drinks without choking. We observed that they did not always have their fluids thickened to the correct consistency. This placed them at risk of choking or developing a chest infection. No records about the use of

prescribed thickener were made. It is important that accurate, timely records are made to show that drinks have been thickened safely. We saw that where staff signatures were required on both of the MARs for the people on thickeners that a line had been scored through the record stating 'No signature required'. The registered manager told us they had done this. There was no explanation as to why. All prescribed medicines must be recorded.

We found that some medicines, which should have been stored in the medicines fridge, were in the drugs trolley, these had to then be destroyed. The fridge was dirty and the temperature was not being recorded. The registered manager and the deputy manager did not have a good understanding of safe disposal of liquid medicines that had been refused and thought it was acceptable to pour it away.

On the day of the inspection we were told by the senior carer they had commenced the medication round just after 08.00 and this was not completed until 11.00. The lunch time round started at 13.00 and finished at 15.00. Therefore there was not the correct length of time between administration of the morning and lunchtime rounds to ensure that people who used the service were receiving their medicines in line with the prescribed timeframes.

We found this was a breach of Regulation 12 (1) (2) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

On the day of the inspection the staffing levels were not sufficient to meet people's needs. We observed one person asking a member of staff to take them to the toilet as they were 'desperate'. The member of staff explained to the person that they could not take them to the toilet as they could not leave all the other people in the lounge, whilst the other two staff were showering another person. There were not enough staff to attend to the basic care needs of people. Staff spoken with also told us they had to do laundry duties as well. There was no time for staff to sit and spend quality time with people.

We asked the registered manager how they assessed the level of care and assistance people required to ensure there were adequate staff on each shift. There was no evidence that a dependency tool was being used and staffing levels were calculated on numbers of people using the service rather than need.

During the morning there was little interaction between staff and people who used the service. There was a lack of stimulation for people who we saw were left sat in the lounge all morning

We found this was a breach of Regulation 18(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Although there was a safeguarding policy in place, staff spoken with had little understanding of what safeguarding meant and did not know the term whistle-blowing. There were instances of poor practice occurring throughout the day in the home, for example, the medicines trolley being left unattended, people's dignity being compromised by being hoisted with their clothes in disarray. However none of the staff members appeared to recognise this as poor practice, so did not feel the need to intervene or report these incidents.

We looked around the home and noted that the carpets in several areas were frayed where they joined the door plates. This was potentially dangerous and could present as a tripping hazard. We saw some carpets were heavily stained on the downstairs corridors. There were some bathrooms and toilets without a waste bin and toilet roll holders/dispensers were missing. This was brought to the attention of the provider and the registered manager by Wigan Council Infection Control Team following their last inspection on 01/12/215

and no action had been taken.

We noted that several liquid soap dispensers were empty; therefore people were unable to wash their hands properly after visiting the toilet.

In the conservatory leading off the main lounge the floor was wet and a pool of water was seen. It appeared that the roof was leaking. The conservatory door was not locked and if a person entered the conservatory they could have been at risk of slipping. The conservatory was cold and could not be used. One member of staff later locked the conservatory door to prevent people from going in.

On opening some windows we found they were not fitted with window restrictors. The windows checked were mainly top opening windows. However the window sills were wide enough for people to stand on and if a person was determined to leave the building they could have got out of the window. On the day of the inspection the deputy manager went around the home checking which windows required a window restrictor. This information was passed on to the provider.

We observed a soiled continence pad on the corridor floor. This was removed by a member of staff. The member of staff did not put on disposable gloves or wash their hands after picking up the pad. Poor hand hygiene places people at risk of infection.

We found in one of the bathrooms that the clinical waste bin was full and there were unsightly brown stains on the inside of the lid.

In the same bathroom, placed in the bath was a perching stool. This was for people to sit on whilst in the bath. This was a domestic bath with no fitted aids to assist people getting into the bath. The use of a perching stool in the bath was unsafe as the stool was not secure. On inspection we found the stool was dirty and had mould on it. There was also a rusty toilet frame over the toilet to assist people on and off the toilet. The condition of the frame meant this could not be properly cleaned.

The cleanliness of the home required attention. Some of the bedrooms had a stale odour and in particular in one room which was unoccupied at the time of the inspection the smell of urine was overpowering.

We found this was breach of Regulation 15 (1) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 – Safe care and treatment

We observed in several areas of the home, boxes of disposable gloves in bathrooms and in bedrooms for staff to use when providing care. Whilst the use of disposable gloves is imperative, people could be at risk of choking if eaten. As most people at the home were living with dementia, safe storage of gloves required attention.

We looked at the accident and incident log and file. Accidents and body maps were recorded in people's care files and in the accident log. The file held monthly overviews of accidents and incidents and actions required, such as referral to GP or falls team.

There was a health and safety file which included monthly audits. These were comprehensive and covered a number of areas and were complete and up to date. We saw that health and safety meetings were attended on a quarterly basis by the registered manager. Issues discussed included equipment in need of repair.

We saw evidence of up to date fire risk assessment, monthly equipment checks, emergency lighting checks,

electrical tests, water temperature checks, regular servicing of equipment and gas safety certificate. Water temperatures had been reported as faulty on 22 February 2016 and repaired on 29 February 2016.

There were records of monthly deep cleans of bedrooms, toilets and bathrooms which were up to date. We also saw records of cleaning tasks, such as shampooing of carpets, cleaning the smoking area and the laundry. Commodes were said to be cleaned and sanitised on a weekly basis, but the records of these were not up to date.

There was an up to date emergency evacuation list pinned up in the office. This included information about the level of assistance each person who used the service would require in the event of an emergency.

We looked at three staff files and saw that the recruitment procedure was robust. Each file included an application form, proof of identification, several references and checks from the Disclosure and Barring Service (DBS) to ensure people were suitable to work with vulnerable people and terms and conditions of employment.

Inadequate

Is the service effective?

Our findings

We observed on arrival at the home at 08.30 that most people using the service were up and dressed and were sitting in the lounge. There was no evidence of preparation of breakfast. Staff told the inspectors that breakfast was not served until 10.00. There was no explanation from the registered manager as to why breakfast was served so late. The home did not offer a flexible breakfast time so people who used the service could dine when they were ready and not sit around waiting.

We observed that people who used the service were not provided with adequate support with their nutritional and hydration needs. We asked the chef for the weekly menus and were told they did not work to a menu, there were no printed menus. We asked how the chef how they knew what to make, the chef replied "I look what's in". We saw there was a small chalkboard with the breakfast menu written on it. This remained unchanged all day. There were no dementia friendly methods to inform people of the day's meals. The chef told us there was a choice of sandwiches 'or something' if they [people who used the service] did not wish to have what was on offer.

We observed a person waiting for breakfast at 10.25. A member of staff asked the person if they wanted porridge or cornflakes. When this person did not respond the member of staff said they would show them. However the member of staff went to the serving hatch and got a bowl of cornflakes, sugared them added milk and gave it the person. There was no interaction or choice offered. People were given toast with butter, there was no conserve offered.

Breakfast was over by 11.30 and at 12.30 people were back sitting at the tables for lunch. Lunch consisted of soup and a cheese roll; people were asked which they wanted. People were not told what the soup was. We asked if the soup was homemade and were told that sometimes the chef makes mushroom soup but the other soups comes in a tub. A dessert of tinned fruit cocktail and cream was offered, we heard the chef say, "The ice-cream is for [named person], other people were not given the choice of having ice-cream. From the two mealtime sessions observed we found the dining room experience was poor. There was no attempt to make the mealtime environmentally pleasant, for example no tablecloths or placemats, no condiments and no glasses of juice or water.

We asked the chef about the meals prepared for people who required a pureed diet or mashed diet and were told that the food was blended. We saw for one person on a mashed diet that the food and fluid charts gave conflicting information as to whether this person was receiving pureed or mashed diet. On one chart (not dated) we saw this person had been given chips, beans and chicken nuggets. There was no information as to whether the food had been pureed or mashed.

We asked the chef how the pureed food was prepared and were told that the chicken nuggets and beans were blended together and the chips were blended separately and gravy added. The same food chart showed that this person had eaten two slices of toast for breakfast. This placed this person at risk of choking. The intake of fluid that day showed that this person had been given drinks of tea at 10.00 and 12.30; there was no evidence of other drinks offered. The fluid chart based on a 250ml cup showed the day's fluid

intake was approximately 185mls of fluid. On 07 April 2016, the food and fluid chart showed this person had porridge for breakfast, and soup and yogurt for dinner and drinks at 10.00 and 13.00. No other food or fluid was recorded. There were also days when no recordings had been made.

There was no evidence of meals for people on pureed or mashed diets having their meals fortified with supplements such as milk; butter and cream to add any nutritional value to their meals.
Staff spoken with had a limited understanding of what constitutes a healthy and nutritious diet for older people.

We found there was no hydration station where people could help themselves to drinks. There was no evidence of people being able to help themselves to snacks during the day. We observed that people had to wait for drinks in the afternoon until the chef reappeared. We observed two people who walked continuously around the home. Both were living with dementia. It is important that for people who are walking off calories should be able to access drinks and snacks regularly to prevent them from being hungry and becoming dehydrated.

We found this was breach of Regulation 14 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 – Meeting nutritional and hydration needs.

Care plans reviewed included little personal information. We were told that some information was kept on computer, but this was not produced for us to see. We were told that only the registered manager and deputy could access the computer system, so other staff, including seniors, would be unable to access information kept there in the absence of the registered manager or deputy.
We saw in the care plans we looked at that people had access to external health services and other social care professionals for example GPs and community nurses.

Allergies were recorded in the medical history section and were in capitals to ensure they stood out. There was evidence in some of the files of referrals to other agencies, such as GPs or Speech and Language Therapy (SALT). However, where recommendations had been made, for example for thickened drinks and soft diet, these had not been adhered to.

Risk assessments and care plans consisted of tick boxes and reviews were out of date in some of the files we looked at. These were supposed to be carried out on a monthly basis, but had not been done in some cases for the last three months. This meant the information contained in them may have been out of date.

We saw for some people that power of attorney documentation was kept within the files.

There was some reference to people's abilities with regard to decision making. We saw in one file a blank mental capacity assessment form. This was used to determine whether this person had capacity. The registered manager told us that sometimes they had. We asked the registered manager and the deputy manager if the form should have been completed and both confirmed it should have been filled in.

Consent forms were signed by the person who used the service, if they were able to do so. However, in many of the files there was no signature of the person who used the service or a representative and no explanation given as to the reason for this. We asked people who used the service about how they were supported in making decisions about their daily routine. One person told us, "Everybody is to be up by 07.00". Another said, "They [night staff] come for you in the morning" and a visitor told us, "My [relative] is given the opportunity to go to bed when they want". Another relative told us, "Sometimes [relative] clothes are not matching but that may be [relatives] choice". No one was able to tell us about whether they were offered a

choice of meals or if they had been asked if they preferred a female or male carer. There was no evidence in the care plans to state if people had been asked about their preference of a female or male carer.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Need for consent

Staff member's understanding of the Mental Capacity Act (2005) (MCA) and Deprivation of Liberty Safeguarding (DoLS) was limited. The training matrix provided evidenced that only five staff had completed training in DoLs. Four senior staff who, at times were in charge of shift had not completed DoLS training.

We asked the registered manager and senior staff on duty, which people were subject to a Deprivation of Liberty Safeguarding (DoLS) authorisation. They were unable to tell us and said they would have to look at the care files in order to be sure. Documentation around DoLS was kept in files. However, in one file we looked at one person's authorisation had expired on 03 January 2016. This had not been automatically re-applied for as there was no system in place to ensure that this was done. Another file we looked at also had an expired DoLS included and we asked the registered manager if an application had been made to renew this one. She told us this had not been done. This meant that the service was unlawfully depriving at least two people living at the home of their liberty.

This was a breach of Regulation 13 (5) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Safeguarding service users from abuse and improper treatment

We looked at the staff file of the last person to be employed at the service. There was no evidence of an induction programme and this member of staff was working on shift. This person was not supernumerary nor shadowing other staff. We asked the registered manager if this person had completed mandatory training, such as moving and handling and were told they had not. During the afternoon we observed this member of staff assisting another member of staff in hoisting a service user. Without appropriate training this could have placed this person and the member of staff at risk of harm.

From the training matrix provided and discussions with staff, it was found that staff had not received training and refresher training updates to enable them to care for people who used the service safely and meet their needs and preferences.

We looked at three staff supervision records and found for one person the last record of supervision was 05/09/2013 and for another member of staff the last supervision record was dated 13/03/14. We spoke with another member of staff who was uncertain what supervision entailed. When this was explained by the inspector what supervision was the member of staff confirmed this had not taken place. The provider had failed to ensure that staff were appropriately supervised and were competent to carry out their role.

This was a in breach of Regulation 18 (2) of the Health and Social car Act 2008 (Regulated Activities) Regulations 2014 Staffing

We asked the registered manager about working with the advanced practitioner nurse (APN) from the local healthcare practice who would provide advice, training and support for staff. The registered manager told us the APN would not attend the home as people had dementia. The registered manager had a lack insight in to what role the APN could offer to the service.

We asked a senior member of staff about caring for and supporting people living with dementia. The member of staff confirmed that most of the people who used the service were living with dementia. The

member of staff told us they had completed basic dementia training but felt this was not sufficient to provide a good standard of care. Staff understanding of caring for people living with dementia was limited. We found that the home did not work to specific model of dementia care for example; The National Institute for Health and Care Excellence (NICE) Guidelines or The Vera Framework which was developed to guide everyday interactions of staff. (The mnemonic stands for Validation –Emotion- Reassure –Activity).

From our observations most people were confined to the lounge area with the door closed. The communal areas and corridors were plain and bland with no reminiscence features or memorabilia. There was nothing tactile on the walls and the pictures on the walls had no relevance to people living with dementia, for example there were no pictures relating to the area or well-known places of interest. There were no rummage drawer's people to look in or any other form of stimulation apart from the television.

People could not freely access the upstairs floor to their bedrooms as the doors were locked and could only be opened by pressing two buttons together at the same time which was difficult for people to do. We saw some reminiscence boxes outside people's doors, however only three of these had items in them. One visitor told us, the environment could be more attractive and their relative was uncertain where their room was. There were no colourful pictorial signs around the home to assist those living with dementia or who were visually impaired.

Requires Improvement

Is the service caring?

Our findings

During the course of the day we observed how staff cared for and supported people who used the service. We observed one person had been sat in the same chair and position for over six hours including mealtimes. We asked staff if this person's personal care needs had been met as they had not been taken to the toilet. Staff then proceeded to get the hoist to move this person. One member of staff had not received training in moving and handling and this could have posed a risk to the person and to the member of staff. We observed this person being hoisted in a manner that compromised her dignity and a member of the inspection team intervened and adjusted this person's clothing and covered them with a blanket as their legs and underwear were exposed. This meant that this person did not receive care and support that was appropriate and met their needs.

This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Privacy and dignity.

People spoken with told us that the staff were kind and caring and treated them with respect. We observed that staff knocked on bedroom and bathroom doors and waited for a response before entering.

We were told by staff that if visitors arrived at meal times they were asked to sit in the lounge area and wait until people had finished their meal. We observed one visitor at breakfast and one at lunch time arrive to take people out during mealtimes. This was disrupting for people who were taken away from the table and for others who were sat close by. If the service was using 'protected mealtimes' this should have been adhered to unless in extreme circumstances.

Family and friends told us they felt that staff listened to their relatives. However, during the day we observed occasions were people who used the services made requests that staff ignored. For example, one person was walking round with a mug of tea asking two different members of staff, "Could I pour some of this out please" this was ignored. This person then went to the chef who then acted on this person's request. There were other requests at breakfast time that went unheeded. These requests were heard by a member of the inspection team.

During the inspection we looked at five care records. These records contained basic information and guidance as to how people who used the service were to be supported. The information recorded in the care plans did not meet people's personal preferences. People who used the service were not involved in decision making processes nor were they encouraged and supported to make their own decisions about their care where they were able to; for example, times for rising, choice of food and how they wished to spend their day.

People's independence was not promoted as people were left to sit in the same chairs for most of the day. We did not witness any of the staff encouraging people to use their abilities and skills to walk around the premises or engage in meaningful conversations or interactions.

We asked the registered manager if the home was caring for people who were ill and nearing the end of their life. The registered manager confirmed the home was not providing end of life care at this time.

Inadequate

Is the service responsive?

Our findings

We looked at the care records for five people who used the service. We saw that prior to anyone moving into the home, the registered manager carried out an assessment to see if they home and staff could meet the needs of the individuals. The assessments were basic and had not been fully completed.

The care records we looked at were difficult to follow and the information was incomplete. We found that the care plans had not been reviewed as required. We were told by senior staff that some parts of the care plans were kept on the computer and only the registered manager and the deputy manager had the password to access the files. This meant that staff were not provided with all the information regarding the people they were caring for. We found that not all the care records has been discussed and agreed with people using the service and/or their relative where appropriate. Families spoken with had not seen their relatives' care plans but did say other family members may have.

The care records we looked at had not been regularly reviewed. The care plans lacked details such as life history and current capacity assessments. This meant there was a risk that staff would not have the information to provide the correct or personalised care to people.

We asked staff what they understood about the term 'person-centred care'. Staff had a limited understanding what this meant and information was not available in the care files to guide staff on people's individual care needs and preferences.

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

We asked about what activities were provided for people. There was an activity coordinator who worked Monday to Friday from 13.00 – 16.00. We observed that the activity coordinator was doing other tasks for example cleaning the tables that had not been cleaned following breakfast than started to lay the tables, handling cutlery without washing their hands.

At 13.45 whilst lunch was still in progress, the activity coordinator brought in large balloons with rice inside and gave them to people sitting in the adjoining lounge area. One person who used the service was heard saying, "It's very noisy", and complained as they did not want a balloon. Observing the activity coordinator at work we found them to be dynamic and loud and not always hearing what people were saying in the busyness of the game. We saw two people were given a black and white jigsaw to complete however no one sat with them to assist and there was table with a closed boxed of dominoes on that no one touched.

We asked for the activity plans and records. We were told by the activity coordinator, "There was no plan of activities as we are changing over to the new care plans". We saw there was an activity sheet to record what activities people should be taking part in. Out of 12 records we looked at nothing had been recorded and the sheets were blank.

During the inspection, the paramedics arrived to take a person to hospital; this was following a visit from the GP. Fortunately this was not a serious emergency admission as the hospital transfer documentation was not ready to give to the paramedics who had to wait for it to be printed off the computer. If this had been an emergency the paramedics would have had to go without current information about the person, including what medication this person was taking. This meant the delay in having information available could have placed this person at risk.

We asked the registered manager how they responded to and dealt with any complaints or concerns raised by people who used the service and/or their relatives. There was a complaints file, however nothing had been recorded and no audit carried out to demonstrate how the service dealt with any concerns or complaints. There was no evidence to show the inspectors that the registered manager was monitoring any complaints and concerns. There was no complaints policy displayed to inform people of the process of how to make a complaint and how this would be addressed.

This was a breach of Regulation 16 (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Complaints

We asked the registered manager how they involved service users and families in the running of the home and were residents/relatives' meetings held. The registered manager confirmed there weren't any systems in place to gather feedback about the service. This meant that the registered manager had not independently sought views and feedback on what the service did well and in what areas they thought could be improved.

This was a breach of Regulation 17 (1) (2) (e) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Good Governance relating to seeking feedback from people.

Inadequate

Is the service well-led?

Our findings

There was a registered manager in post at the time of the 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 and associated regulations about how the service is run.

The registered manager was not available on the morning of the inspection as they were on leave. However, the registered manager came to the home later that day. The deputy manager had recently been promoted to this role and showed they were keen to learn and improve the services at the home.

We observed that throughout the day the registered manager repeatedly asked the deputy manager if certain paper work was in place and if so where was it. This meant in the absence of the deputy manager the registered manager may not have been able to access some of the paperwork required.
We asked the registered manager to tell us how they monitored and reviewed the service to ensure that people received safe and effective care. The registered manager was not able to tell us how they monitored the quality of the service and there was little evidence to show that regular checks and analysis of findings were addressed.

We saw there were records of monthly deep cleaning of bedrooms, toilets and bathrooms, which had been ticked as done by the domestic team and were up to date. However the records did not collate with the findings of our tour of the premises. We found that some bathrooms had not been deep cleaned and some bedrooms had an unpleasant stale odour. The registered manager had not checked the tasks had been completed to a satisfactory standard or completed an audit of the cleaning schedule.

We saw records of cleaning tasks, such as shampooing of carpets; however it was apparent that the downstairs carpets had not been deep cleaned. Commodes were said to be cleaned and sanitised on a weekly basis, but the records of these were not up to date. This meant the registered manager had not checked the records to ensure the tasks had been done and that the documentation had been completed.

There was no evidence of medication audits to show that the registered manager had checked to see that people were receiving their medication in a safe and timely manner and the MARs were being completed accurately.

It was evident from the food and fluid charts we looked at that the registered manager had not audited the food and fluid charts. Regular auditing of the charts would have highlighted that these were incomplete and that the food being offered to some people, for example those people on purred or soft diets was inappropriate and placed people at risk of choking. The registered manager had a lack of understanding as to the importance of ensuring people were provided with a nutritious diet that was appropriate to their assessed needs.

Staff spoken with told us they did not always feel supported by the registered manager. Staff felt the service

would benefit from increased staffing levels. We observed that staff were working very hard to complete tasks; however this was at the expense of spending time with people who used the service.

Due to the lack of up to date staff training, staff also had a limited understanding in what caring for people living with dementia entailed and agreed they would benefit from further training.

Two spoken with were uncertain of the term whistle-blowing and had to be prompted by the inspector as to what this term meant. This meant that staff had not been supported by the registered manager or the provider to ensure that staff were confident in their role.

We asked the registered manager for the service user guide. The service guide was kept on the computer, therefore it was not easily accessible to people who used the service or their relatives. Some of the information in the service user guide was incorrect. For example, 'Service users can be sure that they are protected by the organisations policies and procedures with regards to safe administration, recording and storage of medicines and that they will receive medications at the prescribed times. The service user guide in relation to meals stated, 'Special diets and personal preferences are catered for. We [The Oaks] provide a four weekly menu which is reviewed on a regular basis and residents are welcome to suggest changes at any time. It was also stated that breakfast was served from 08.30, which on both days of the inspection did not happen. The address of the Commission should people wish to contact us, was not listed in the guide.

We checked our records before the inspection and saw that we had received some notifications of accidents and incidents that the CQC needed to be notified about. We saw that there had been one notification regarding an application for a DoLS authorisation had been submitted to the CQC in February 2016. During our inspection we found two DoLS authorisations had expired and that the registered manager had not applied for a renewal of the authorisation. The registered manager told us this had not been done. There was no system in place to alert the registered manager when a DoLS was due to expire or audit in place to check DoLS were being monitored.
The registered manager had a limited understanding of the importance of MCA and DoLS.

We found that the provider and the registered manager had not been proactive in assessing and monitoring the quality of the service as required. The failure of governance and oversight demonstrated by the provider is a significant risk to the service.

This was a breach of Regulation 17 (2) (a) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Good governance.