Kingsley Care Homes Limited

Four Oaks Care Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**Inadequate**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

This inspection took place on 7 and 8 December 2017 and was unannounced. Four Oaks was last inspected in July 2017 and was rated as requires improvement when no breaches of the Health and Social Care Act 2008 were identified.
At this inspection we found breaches in six regulations of the Health and Social Care Act 2008, including concerns that placed people at serious risk of harm. These were in relation to service user safety, falls prevention, mitigating known risks, training of staff, medication, staffing levels and shift management, the monitoring of fluids and the governance and leadership at all levels.
Following the inspection we asked the service to take some immediate action and told the home to produce an action plan to address the issues we had found. We returned to Four Oaks on 19 January 2018 to check that these actions had been taken and the action plan was being implemented. Our findings for the 19 January visit are reported at the end of each section of this report.
Full information about the CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded. You can see what other action we have told the provider to take at the back of the full version of the report.
Four Oaks is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. The Care Quality Commission (CQC) regulates both the premises and the care provided, and both were looked at during this inspection.

Four Oaks is a modern purpose built property which can accommodate up to 62 people in four separate units on two levels. Two units specialise in providing care for people living with dementia. At the time of our inspection there were 56 people living at Four Oaks.

At the time of our inspection there was a new manager in place at the home who told us they had started to complete the application from to be registered as the manager with the CQC. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

There were insufficient staff on duty to meet people's assessed health and well-being needs. Staff were task orientated and were not visible in communal areas of the home as they were supporting people. Relatives told us they had had to support their loved ones themselves as there had not been any staff available.

Risks had not been clearly assessed and guidance was not available for staff to follow to mitigate any risks identified. For example people had had multiple falls and did not have a falls risk assessment in place. Hot kettles were left in the kitchenettes of each unit which people had access to with no staff being present. This posed a risk of scalding for some people living at the service. Behaviour management plans were not in place for those people who displayed behaviour that challenged the service.

Initial care plans for a person moving to the service were being written on the morning of their arrival. The staff team were not aware of this person's needs. Most care plans were brief, generic and did not provide sufficient details to guide the staff to deliver person centred care. Some care plans were more detailed, for example the dementia care plans.

People and relatives said they had not been involved in developing the care plans.

Staff said they did not have time to access the care plans on the computer system used at the service. Handover of relevant information between shifts was not robust, with staff stating they did not always receive the information about any changes in people's health or well-being.

Medicines were not safely managed. On the first day of our inspection the morning medicines round took so long that one person had to miss their lunch time medicine as there was not enough time between doses. There were no protocols in place as to when people were to be administered 'as required' medicines. One person had been administered an 'as required' medicine that made them sleepy. There was no indication in their care notes that they had been agitated and required this 'as required' medicine to be administered.

Fluid charts were used to monitor people's fluid intake. However they did not specify a target amount the person should have each day and each day's total fluid intake was not calculated, meaning the information was not analysed to ensure the person had had enough fluids.

There was no information available for the care staff regarding the amount of thickener to be used in a person's drink to reduce the risk of choking.

Staff training was not up to date. The training matrices used by the home to identify staff training needs were not up to date. New staff were placed on the rota before completing the training identified as mandatory by the home and considered essential for new staff to carry out their role.

The service had a complaints procedure in place and we saw complaints had been responded to. However one response stated staff training was reviewed each week but this was not possible as the training matrices and staff training were not up to date.

There was a lack of governance at the home. Audit systems either were not in place or were not robust and had not identified the breaches in the Health and Social Care Act 2008 found at this inspection. Feedback from people living at the service, relatives, health professionals and staff about staffing numbers had not been acted upon as the service had an over reliance on a dependency tool that calculated how many staff were required and was not fir for purpose.

We have made a recommendation that the activity co-ordinators receive suitable training with regard to activities for people living with dementia.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures '.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still 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 this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to 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 so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

On our return to Four Oaks on 19 January 2018 to check what improvements had been made we found the service was implementing their action plan. Staffing levels had increased, including the number of nurses on duty in the morning. Senior care members of staff had been trained to administer medicines on one residential unit. The medicine rounds were monitored and completed in a timely manner. Protocols had been written for medicines prescribed 'as required.'

Risk assessments had been reviewed and updated, although some, for example for managing people whose behaviour could be considered as challenging were not sufficiently detailed. A falls management system was in place, with crash mats being used to reduce the risk of injury and sensor mats in place to alert staff if a person was getting up and may need support.

Kettles were kept in a locked cupboard in the kitchenettes. Microwave ovens had been removed from the units for people living with dementia.
Staff handovers were taking place so that staff had up to date information about any changes in people's support needs. Shifts had additional structure with allocation sheets being used on each unit to show who each staff member would be supporting.

Information was in place about the amount of thickener to use in people's drinks where they had been assessed as being at risk of choking. The target amount of fluids to consumed each day and the actual consumed was not recorded.

Staff training had been arranged, with some already having been completed. New staff attended a three day training course before starting to work at the home. All staff had been enrolled on the relevant on-line courses.

A quality audit system linked to the provider's C 360 compliance programme had started to be used. We discussed the use of the dependency tool with the deputy operations manager who said that the tool would be reviewed.

It was too early to assess what impact that these changes have made on the quality of care and the quality of people's lives. We will look at this at our next inspection.

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.

There were insufficient staff on duty to meet people's assessed needs.

Risks were not always assessed and guidance to mitigate any identified risks was not in place.

The medicine rounds took so long that people missed their lunchtime medicines. Protocols were not in place to guide staff as to when 'as required' medicines should be administered.

Is the service effective?

Inadequate

The service was not effective.

Staff training was not up to date. The training matrices used to identify training needs were not up to date.

Staff did not receive information about new people moving to the home or any changes in people's health or well-being in a timely manner.

Charts to monitor people's fluid intake were not effective. Guidance for the use of thickeners in drinks was not available.

Is the service caring?

Requires Improvement

The service was not always caring.

People and their relatives said the staff were kind and caring. Interactions between staff and people living at Four Oaks were tasks orientated.

People's dignity was not always maintained as bedroom doors were left open and staff were not able to check on people frequently enough in case they required support.

People and their relatives said they had not been involved in developing their care plans.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Most care plans were brief and did not include enough information for staff to deliver person centred care.

A complaints procedure was in place but the response to one complaint was not accurate as it stated staff training was reviewed weekly.

Is the service well-led?

Inadequate

The service was not well led.

The provider did not have a robust quality assurance system in place.

Accident and incidents were not analysed to assess any changes that could be made to reduce the risk of any re-occurrence.

The provider had not acted on feedback form people, relatives, health professionals and staff about the staffing levels.

Four Oaks 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 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.

The inspection was prompted by a number of safeguarding notifications received by the Care Quality Commission (CQC) and 'Share Your Experience' forms sent to the CQC by relatives of people living at Four Oaks. Share Your Experience forms are sent directly to the CQC and enable people to give their feedback about a service.

The information shared with CQC about the home indicated potential concerns about the management of the risk of falls and the staffing levels at the home. This inspection examined these areas.

The initial inspection took place on 7 and 8 December 2017 and was unannounced. The first day of the inspection was carried out by three inspectors and an 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 care service. The expert had personal experience of services for people living with dementia. Three inspectors returned for the second day.

Due to our concerns about the service we told the home to take some immediate action to address the issues of most concern and risk to people and also to produce an action plan to address all of the issues we had found. Two inspectors returned to Four Oaks on 19 January 2018 to check that immediate action had been taken and the action plan was being implemented. Our findings for the 19 January are reported at the end of each section of this report.
We did not ask the provider to complete a Provider Information Return (PIR) before this inspection as they had completed a PIR in June 2017. The PIR is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed other information that we held about the service including previous inspection reports and notifications. A notification is information about important events which the service is required to send us by law.

We also obtained feedback from the local authority with regard to the safeguarding referrals that had been made.

During the inspection we observed interactions between staff and people who used the service. As some people were not able to tell us about their experiences, we used the Short Observational Framework for Inspection (SOFI) during the lunch period and in the lounge areas of the home. SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

We spoke with 10 people who used the service, nine relatives, the manager, 16 care staff and five nurses. We observed the way people were supported in communal areas and looked at records relating to the service. These included nine care records, four staff recruitment files, daily record notes, medication administration records (MAR), maintenance records, accident and incident records and quality assurance records.

Inadequate

Is the service safe?

Our findings

Three people's relatives did not feel the home was safe. Comments received included, "I hate to say it but no, the home is not safe. There isn't enough staff on duty", "I don't believe it is safe, thankfully as a family we can visit three times a day to check on [person's name], but we worry when we are not around" and "I don't have much confidence in the home, my [person's name] has had a number of falls and they haven't done anything about this."

One other relative we spoke with and three people who lived at the home told us they felt safe at Four Oaks.

We looked at how risks were managed by the service. We viewed the care records of four people who had experienced falls at the home. We found that there were no falls risk assessments completed and there was no evidence that these incidents had been reviewed or that preventative measures such as the use of bed rails, falls sensors or crash mats had been considered. For example we found one person had had nine falls in the home from June to December 2017. We found five of these falls were in their bedroom. The most recent fall had resulted in an admission to hospital with the person being diagnosed with a fractured hip. Another person predominantly stayed in their bedroom due to staff being unable to manage their behaviours when they were in communal areas of the home. We found there had been six recorded incidents in the person's bedroom from September to December 2017. We found two incidents of the person damaging their bedroom, one incident when they had been crawling on the floor and three incidents where the person had fallen in their bedroom.

We did not see any referrals to the local falls team being made for any of the four people. The falls team is a specialist team of professionals who provide advice for care homes in the reduction and prevention of falls.

The risk assessments did not clearly identify risks to individuals and there were no individual falls risk assessments in place on how to mitigate risks of falls. We found the provider had not considered how to minimise potential falls. Furthermore, we found the provider had not recorded how they re-assessed the person after each fall.

The Care Quality Commission had received a 'Share Your Experience' form from a visiting relative who had observed one person try to make themselves a drink using hot water from a kettle, putting themselves at risk of scalding themselves. We were told that the kettle on this unit was now kept in the nurse's station so it was not accessible when staff were not in the kitchenette.

However our observations on all four units during both days of our inspection were that the kettles were left in the kitchenettes. We noted that kettles were left after being boiled with hot water still in the kettle and no staff were present in the kitchenette. We also noted that microwaves were situated on the edge of the work services within reach of people living at the service. Toasters were also left on the work services. People living with dementia may not be aware of the risks of using or moving these items. We asked to see the risk assessments for these items to evidence that the risks to people living at the home had been considered, assessed and any actions identified to reduce the risks had been identified. These risks had not been

assessed and risk assessments had not been written.

People who displayed behaviours that challenge, with the potential to cause harm to other people, had not been manager effectively and the risks had not been recorded into their support plans and risk assessments. This meant staff were not fully aware of the risks people could pose or how to mitigate those risks. When incidents took place, staff did not respond appropriately to reduce the risk of reoccurrence or follow the provider's policies and procedures. We found three people were known to display behaviours that challenge, with the potential to cause harm to other people. One person required one to one staff support at all times to manage their behaviours. We found they had a behavioural support management plan, however this plan contained limited information and did not accurately record how staff needed to approach and support this person in order to manage their behaviours.

Assaults on people and staff occurred regularly in some units at this service. During our inspection, staff openly discussed their concerns and fears about coming into work, the difficulties they faced at work trying to deliver safe care and support to people and the effects of this on their own health and well-being. We found a high percentage of staff had not received training in managing behaviours that challenge. This meant staff were not trained to recognise when people's behaviours were changing, such as when people known to assault other people were becoming agitated and how staff needed to safely support these people.

The provider had not taken reasonable practicable steps to mitigate risks to the health and safety of service users. This was a breach of Regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 with reference to 2 (a) (b).
We also saw that people who were assessed as being at risk of dysphagia (choking) had been prescribed thickeners to reduce this risk. We were told that the thickening powder was added to people's drinks by the care members of staff. The food and fluid chart did not record the consistency of fluid the person required or any guidance as to how much thickener needed to be added to people's drinks. Different makes of thickeners were used at the home and each one used different amounts of thickener to achieve the same consistency. We spoke with two staff with regards to one person's thickener. They were unsure what the correct consistency of fluid the person required. This meant people were at an increased risk of choking as the care staff did not have clear information available to them about the consistency of fluids each person required. This was a breach of Regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 with reference to 2 (b).

We inspected the systems in place for the storage and management of medicines. The service had a locked treatment room where the medicine trolleys were securely stored. The medicine's fridge temperature and the treatment room temperature had been recorded daily to ensure medicines were stored at the correct temperature to maintain their efficacy. Some prescription medicines are controlled under the Misuse of Drugs legislation, for example morphine, which means that stricter controls need to be applied to prevent them from being misused, obtained illegally and causing harm. We saw controlled drugs were appropriately and securely stored and the stock balance checked weekly to ensure it was correct.

There were no protocols in place for medicine prescribed to be taken 'as and when required' (PRN) which meant that people may not have received medication when needed. Protocols give direction to staff as to how and when these medications should be administered as they are not routine. One nurse said, "They are not something I have ever seen." This meant that staff may not be aware when a person needed medicine, such as pain relief, because there was no guidance to show how people communicated that they were in pain when they were unable to verbalise how they were feeling.

During the inspection we found one person had been recently prescribed a PRN medication to help the person when they became agitated. There were no PRN protocols in place to determine why this medication was required. We viewed the person's medication administration record (MAR) which indicated this was administered on 2nd, 3rd and 6th December 2017. Although it was recorded as given on the 3rd, we found this was an error made by the nurse. We found no rationale to why this medication was administered and on viewing the person's care notes we found no notes recorded that would indicate why this medication had been administered. During the inspection we discussed this further with the person's family member who was distressed as she observed them sleeping and not engaging with their food or in conversation. We were informed this was out of character for the person and was a result of the medication. This meant this person had been given a medicine that had a sedative effect on the person with no evidence that it had been required.

We found that medicines prescribed to be given in the morning were being administered up until 1.10pm. We were informed by the nurse on duty that one person was meant to be administered an anti-depressant medicine at 9am and 1pm; however the first dose was administered at 1pm. When asked the nurse reported that she did not have the time to administer this any earlier. This meant the person was unable to take their prescribed 1pm (lunch time) tablet due to there not being the required gap between the doses and therefore had missed a prescribed dose of medication.

During the inspection we reviewed the medicines files and saw examples on people's MAR where medicines had not been signed for. We found two people had not been administered their pain relief patch on the correct day. This meant the two people may have experienced avoidable pain.
One person's care plan stated they were able to administer their own medicines with support from a trained member of staff. However we saw their medication was left on their bedside table. We did not see a risk assessment in place for the storage of the medication. People living with dementia may wander into other people's rooms and so could have had access to the person's medicines.

We saw minutes from a meeting held with the local GP practice on the 19 October 2017. At this meeting the GPs raised the issue of the length of time being taken to complete the medicine rounds and errors made when administering medicines. We did not see that the service had taken any action to address these concerns.

Feedback received from nurses confirmed they didn't feel the number of nurses on duty were sufficient to meet people's needs. Comments received included, "I am fearful for my registration, we do not have enough nurses on duty", "As you can see I have not stopped all morning, this has now impacted on one person because I will have to omit their afternoon tablet due to them having their morning medication so late, we need the staffing looking at", "As soon as I finish a medication round it`s almost time to start the next one" and "The nursing staff during the day is inadequate, the manager knows this."

Where people were prescribed topical creams and lotions we found that there were no body maps to inform staff where the creams needed to be applied. This meant we could not determine if people had received theses medicines as prescribed.

Failure to ensure medicines were administered safely and as prescribed constituted a breach of Regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 with reference to 2 (g).

During our inspection we observed there were not enough staff to attend to people's physical needs promptly and we found long periods where communal areas, such as the lounges were left unsupervised. One nurse told us, "The kitchens and lounges can't be manned all the time as staff are called away to

support people. This increases the risk of falls." During the inspection we observed people waiting for staff to support them. We spoke to one person in their bedroom who told us they had been waiting for an hour for staff to support them with their continence care. We noted this person's call buzzer was on the floor, which meant the person would need to shout for assistance due to the buzzer not being in close proximity. We pressed the buzzer for this person, we found staff were busily engaged supporting other people. Once the staff were aware this person needed support we found they waited an additional 10 minutes.

We spoke with two relatives who were distressed that their loved ones had had to wait for long periods to be supported to change their incontinence aides. One relative told us, "Like today, I found him already soiled at about quarter to twelve. I told staff who said they will clean him." We saw this relative an hour later and their loved one had yet to be supported to change. Another relative told us they had been waiting for three hours for their loved ones incontinence pad to be changed. Another relative told us, "I have had to change [Name] myself, as staff are too busy, saying 'I can't leave the lounge', or 'I am going for my lunch."

During our lunch time observation we found people's family members provided a number of care related interventions due to the lack of staff. We observed one person's family member assisting two people with their meals. Once the care worker had completed their tasks such as serving meals to other people, they were then on hand to take over, however we observed the staff member felt under pressure and stood over the person while assisting them with their meal. This was not dignified and meant the meal time experience was rushed.

People living at the home thought there were not enough staff on duty. People said, "They are probably short of staff most afternoons", "I feel the staffing is at minimal level. They can be short of staff any time or day in the week. For example, there is pressure when staff are off sick" and "Staff don't always answer my buzzer, well, can take some time."

We also received negative comments about staffing levels from people's family members. Comments included, "There is never enough staff, it's not the carers fault and can only be corrected by the management", "As you will see there isn't enough staff around, thankfully on this floor people's family visit often and we can keep an eye on things" and "In the past staffing levels were fine, but in the last five months the staffing levels have been inconsistent."

We asked staff if they thought that staffing levels were appropriate. Comments received were negative and staff felt the staffing levels need to be increased. Comments included, "The staffing at the moment is not safe, we are doing our best but an additional staff member would help", "I don't like to moan and I just get on with it, but the staffing levels are not great", "More staff would be a dream, we don't have the opportunity to sit down with people", "Most of the residents on this unit need two to one support with their personal care which then leaves just one carer looking after everyone else" and "We do our best to get around when the call bells go off but if we are busy with another resident there is not much we can do until we have finished."

We discussed this with the manager and were told that a dependency tool was used to calculate the number of care staff required. We also saw this had been the answer given at a relatives meeting in November 2017 and at the GP's meeting in October 2017 when the staffing levels had been questioned. However by speaking with people, their relatives and staff, and by observing the interactions between staff and the people living at the home, it was clear there were not enough staff on duty to meet people's assessed health and wellbeing support needs. In addition, staff did not have time to provide engagement and stimulus to the people living at the home. This meant the home had an over reliance on a dependency tool for calculating staffing levels which did not provide sufficient staff numbers to meet peoples assessed needs. We reviewed the dependency tool and felt it was not fit for purpose at this location.

The lack of sufficient staff was a breach of Regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at the recruitment files for four members of staff. We found they all contained fully completed application forms detailing previous employment histories and an explanation of any gaps in employment history. Also included were two references from previous employers, a health questionnaire and evidence that appropriate checks had been made with the disclosure and barring service (DBS). The DBS checks to ensure that the person is suitable to work with vulnerable people. This meant the people who used the service were protected from the risks of unsuitable staff being recruited.

From the training matrix we saw only 37% of the staff team had completed training in safeguarding vulnerable adults. Staff we spoke with were able to explain the correct action they would take if they witnessed or suspected any abuse taking place. One person we spoke with said they had raised a safeguarding alert against an agency member of staff. We saw that a robust protection plan had been implemented to help ensure that the person was not at further risk. However the person was not aware of their protection plan. We raised this with the care staff on duty and they then discussed the protection plan with the person. This meant that whilst a low percentage of staff had completed formal safeguarding training, we were satisfied that existing procedures for safeguarding vulnerable adults were adequate and staff knew how to raise a concern.
We checked the systems that were in place to protect people in the event of an emergency. We saw personal emergency evacuation plans (PEEPs) were in place for all people who used the service and a copy was kept by the main door. These plans briefly detailed the support each person would require to evacuate them from the building.

We looked at records for the maintenance of equipment within the home. We saw weekly tests were completed for the fire alarm system, call bell system and bed rails. Records also showed equipment within the home, for example the emergency lighting, fire extinguishers, hoists, wheel chairs and gas checks had been completed in line with the manufacturer's instructions. Regular checks of the water system were also completed. This should help to ensure that the environment people lived in was safe.
We saw that all areas of the home looked clean and well maintained and there were no malodours in the building. We saw staff used personal protective equipment (PPE) such as disposable gloves and aprons when completing personal care tasks. We found monthly infection control audits had been completed up until September 2017. The home consistently scored highly in these audits, although actions that had been identified, for example ensuring new starters had completed infection control training and writing a procedure for decontaminating curtains and blinds were repeated each month. This meant the service had a high level of compliance with infection control but had not implemented actions from their own internal audits for further improvements.

On our return to Four Oaks on 19 January 2018 to check what improvements had been made we found the risk assessments had been reviewed. A falls management policy was in place and measures had been taken, for example using crash mats to reduce the chance of people being injured and sensor mats to alert staff if someone was getting up. The service had liaised with people's GP's to request a referral to the falls team for more specialist advice where appropriate. Hourly monitoring checks were being completed. One staff member said, "We have improved greatly on falls management of the home, we know now what we are meant to be doing." This meant the risk of falls had been mitigated where possible.

Challenging behaviour plans had also been reviewed, however these were of variable detail and required additional guidance for staff. There had been a reduction in the number of incidents of challenging behaviour since our inspection in December 2017. In discussion with the operations director we were

informed a behavioural specialist was due to support the home to update people's positive behavioural support plans and provide training to staff.

Kettles were now stored in lockable cupboards in the kitchenettes and the microwave ovens had been removed in the units for people living with dementia. This meant the risks of these items had been reduced.

The food and fluid charts had been amended to include the amount of thickener each person required to be added to their fluids to reduce the risk of choking.
We saw that PRN protocols had been written on all units. This would guide staff as to when a person may require when required medicine to be administered. Body maps and charts were in place for care staff to sign when they had applied any prescribed creams.

Staffing at the home had been increased. There were now three nurses on duty until 2pm. Two senior care workers had been trained to administer medicines on one residential unit. This meant one staff was available to administer medicines on each unit. The timing of the administration of medicines via a percutaneous endoscopic gastrostomy (PEG) tube had been changed. This meant the medicines rounds were completed in a timely manner. The start and finish times of the medicines rounds were monitored and a ten point monitoring chart had been introduced to ensure all medicines had been administered as prescribed.

The number of care staff had also been increased. Staff were positive about this change. On one unit an activities co-ordinator assisted staff in the morning during breakfast. However the staff on this unit still felt they were sometimes short staffed. We discussed the dependency tool with the deputy operations manager and how it was used. They said the tool was to be reviewed to ensure it was fit for purpose.

It was too early to assess what impact that these changes have made on the quality of care and the quality of people's lives. We will look at this at our next inspection.

Inadequate

Is the service effective?

Our findings

The home completed a pre-admission assessment before people moved to Four Oaks to ascertain whether their needs could be met by the service. This was completed wherever the person was living, for example their own home, another care setting or in hospital.

However on the day of our inspection one person was moving into one of the units. The nurse on the unit told us, "We have got a new resident coming in later and none of us knew anything about it – no one told us." The nurse went on to say that they had been told at the morning handover, but there was nothing in the diary and no care plans were in place. The staff working on the unit were also not aware that a new person was moving in that afternoon. A member of staff told us that if they had been off for a few days they weren't informed about new people who had moved to the service since they had been off. They said, "We can look on CareDocs (the care planning system used at the home), but we don't have time to check at the start of a shift."

We observed the morning handovers on two units. We saw the nurses met to handover information about any changes in people's health, welfare and support needs. However the care members of staff were not part of this handover. The nurses were meant to pass on any information to the care staff members as required; however staff told us they did not always receive the handover information from the nurses on duty.

This meant that even though a pre-admission assessment had been completed the initial care plans had not been written in a timely manner and staff were not always informed of people's needs through the handover process. Therefore the staff may not provide the person with the correct support when they first move in or if their needs have changed. We saw an action dated November 2017 on the local authority service improvement plan was for the 'Implementation of frequent and quality handovers on each unit.' From the evidence we collected this had not been achieved and put the health and wellbeing of people living at the service at risk.
This was a breach of Regulation 9 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 with reference to 3 (b).

We looked at the training and induction provided for the staff team. Staff told us they had shadowed existing staff for at least a week as supernumerary to the rota. This could be longer, depending on the staff member's previous experience of working in the care sector.

The manager told us the home used a combination of taught courses, for example moving and handling and medicines management and e-learning courses. Staff who were new to care were also enrolled on an on-line care certificate qualification. The care certificate is the national good practice standard care staff should work to and included modules for duty of care, privacy and dignity, health and safety and equality and diversity. However the training matrix for the on-line care certificate showed only 40% of staff had completed these modules. The service had also identified seven e-learning courses it considered to be mandatory, including fire safety, first aid, food hygiene, infection control, medication safety, moving and

handling and safeguarding adults. Only 44% of staff had completed all these courses, with 33% of staff having completed none of the identified mandatory courses.

One new member of staff we spoke with said that they had completed no training since starting at Four Oaks nine weeks previously. A nurse told us, "I felt like I was thrown in" when they first starting working at the home. However another staff member who had been at the service over six months said that they had completed the care certificate and on line training in safeguarding and oral care when they first started. They said they had been shown how to use the hoists by the then manager but were still to complete a formal moving and handling course.

The training matrix we viewed was not up to date. It recorded that courses for dementia and challenging behaviour had been booked for 33 staff members (47%) on the 31 October 2017 but did not record who had actually attended this course on that date. 32 staff (46%) had previously completed dementia training however staff we spoke with said that many staff still required this training. Most people living at the home were living with dementia and as previously noted in this report some people displayed behaviours that challenged the service.

We discussed this with the new manager. They told us they were planning to give staff allocated time on their rota to complete the training courses. For new staff these would have to be completed before they were included in the rota. The administrator for the home had only been shown how to log into the e-learning training provider in December 2017. They were now able to update the training matrix and review which staff were required to complete training modules. This meant the manager had not had up to date information on the staff training requirements at the home and therefore did not have oversight of the competency of the staff that they were deploying.
The lack of suitable training meant that staff were not provided with the skills to meet people's assessed needs. This was a breach of Regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 with reference to 2 (a).

We also saw that the new manager had undertaken supervisions with all the staff since joining the service five weeks before our inspection. They said they planned to complete staff supervisions every three months. Prior to this we saw that the supervisions had been inconsistently held, with some being completed but other staff not having any.

Feedback from the staff we spoke with was that morale at the home was low. One said, "Staff are really fed up now – the morale has never been so low – I know people are going to leave." Staff also said that the number of staff on duty, including nurses, had been reduced the week of our inspection. Staff told us, "We weren`t told about the staff changes they just did it without talking to us and now we can`t manage." We were told that staff sickness had been an issue which had impacted on the number of staff on duty and the support they were able to provide. The new manager told us, confirmed by the staff we spoke with, that they were now conducting return to work interviews following a period of staff sickness. This was enabling the new manager to manage staff sickness, which was now reducing. The minutes from a recent staff meeting showed the staff had raised their concerns, including about staffing levels, and these had been acknowledged by the new manager. The new manager planned to hold staff meetings every three months to increase the communication with the staff team.

This meant that the staff team were now receiving more support from the manager; however previously this had not been consistently provided resulting in low morale amongst the staff team.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of

people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

Those people who required a DoLS had one in place. However we found only 39% of the staff team had completed training in the MCA, and they did not always understand their roles and responsibilities in relation to the Act. However they were able to give appropriate examples around giving people choice and control over their care, for example people were able to get up and go to bed when they wanted to. On the first day of our inspection we arrived at 7am and found that the vast majority of people were still in bed. The night staff we spoke with said, "We don't have to get people up if they don't want to."

We found that consent forms were not always completed correctly. We found three people were perceived to lack mental capacity, however their consent forms were worded that they had given consent to care and treatment and for professionals to access their care plans. Another person had been assessed as having the capacity to consent to their care and treatment at Four Oaks, but a DoLS application had been made to the local authority. However following an assessment by the local authority it was deemed that the person did not meet the criteria for a DoLS as they had capacity to make their own decisions.
We looked at how people were protected from poor nutrition and were supported to eat and drink. We saw that the chef had a list of people's assessed nutrition needs, for example if they required a soft, pureed or fortified diet. The chef prepared the pureed meals the same as all the others and then pureed each portion separately. The chef also had details if a person had cultural or personal preferences for their food. For example one person did not eat meat and other people had diabetes. However we saw from the minutes of a heads of department meeting in November 2017 that the chef had not always been updated when people's needs changed. The clinical lead had been tasked with ensuring the chef had an up to date list of all people with a prescribed diet. We will check that the information the chef is given remains up to date at our next inspection.
We saw that people had a choice of two main meals at lunchtime. The chef told us that people could also ask for an alternative, such as an omelette, if they did not like the menu choices. The evening meal was a choice of soup and sandwiches. As previously mentioned in this report, some people chose to get up late. We did not see any opportunities for people to have their meals plated and re-heated later, although there were microwaves on each unit. This meant that people may not want their main lunchtime meal as they had recently eaten their breakfast.

We were told that the lunchtime meal was served at 12.30 pm and people started to go to the dining room on each unit for this time. However we noted that on the day of our inspection the meal was not served until 1pm. As previously noted in this report people's relatives became involved in supporting other people with their food as the staff were already busy supporting people. Also on one unit the care members of staff had to go to the kitchen to collect more food as not all the people had been served. This meant some people had finished their meal before others had been served theirs.

The chef said that snacks were available on each unit for people in the evening and at night, such as biscuits and crisps. The night nurse also had a key for the kitchen in case anyone was hungry during the night. However one person told us, "I wish they could serve main meal at tea time instead of lunch time. I can feel hungry at night with having just soup and bread at tea time about 5pm." We were also told that there were

not always snacks available on the units in the evening.

The kitchen had been inspected by the Food Standards Agency in November 2017 and had been awarded a rating of 3 (out of 5) which means generally satisfactory.

We saw food and fluid charts were in place where required. These should be used to monitor people's food and fluid intake if they had been assessed as at risk of malnutrition or de-hydration. However we found that the charts did not include a target amount of fluid recommended for each person. The daily totals also had not been calculated. This meant that whilst people's fluid intake was recorded it was not being used in a meaningful way to monitor if they were drinking sufficient fluids. The matter of incomplete charts had been raised by the GP at their meeting with the home in October 2017.

The lack of support for people to eat and the lack of meaningful fluid charts was a breach of Regulation 14 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw that each person at Four Oaks was registered with a local GP. As noted earlier in this report a meeting had been held with the local GP practice in October 2017 to discuss areas of concern. The GP's did state that there had not been any instance where people had not been referred to the GP when their health had been declining. However there were concerns around the information made available by the staff at Four Oaks when they visited and that sufficient information was not being supplied to the GPs when a new patient was being enrolled at the GP practice. We noted referrals had been made to the speech and language team (SALT) but the advice and guidance they gave was not always communicated to the staff delivering care. We saw the service provided appropriate pressure relief care for people at risk of developing pressure area sores. Pressure relief mattresses were used as required and records maintained of when people were supported to re-position.

On our return to Four Oaks on 19 January 2018 to check what improvements had been made, we found a new staff handover system had been introduced. All care staff on the incoming shift attended a handover meeting with the nurse or senior care staff from the previous shift. This gave information about each person's health and wellbeing and any changes in their support needs. Staff told us that they liked this system as they were better informed about people's needs. We also observed staff sharing ideas on how to support one person to complete their personal care.

We were shown a new induction training course had been introduced. New staff completed three days of training, including safeguarding, moving and handling, mental capacity act and dignity in care before starting to shadow experienced staff in the home. Staff who had not had this training when they joined the service had also completed these three days of training.

Training courses had been booked and were underway. Staff told us of the training they had completed and those that had been booked, including dementia awareness, challenging behaviour and managing falls. Staff told us they had all been registered for the on-line training courses and were in the process of completing them.

Staff told us that morale had improved.

The chef continued to have up to date information about people's dietary needs for soft, pureed or fortified food. They were able to describe those people who were diabetic and that one person was a pescatarian (will eat fish but not meat); however this was not recorded on the diet sheet. We discussed this with the deputy operations manager who said they would ensure that the chef adds this information so it is available

to all staff working in the kitchen.
The total amount of fluids consumed each day was not recorded on the food and fluid charts.

It was too early to assess what impact that these changes have made on the quality of care and the quality of people's lives. We will look at this at our next inspection.

Requires Improvement

Is the service caring?

Our findings

Throughout our inspection visit, we observed how care and support was delivered in communal areas of the home. During these observations we found care staff had very little time to positively engage with people. For significant periods of the day, the only interaction people had was centred on their task-based care. Staff we spoke with told us they would like to spend more time with individuals but the daily routine of the home meant this was not possible. This meant that the majority of staff interactions were centred on task based activities as the staff did not have the time to spend other time with people.

We observed some positive interactions when staff were supporting people, with staff explaining what they were doing and chatting with the person they were supporting. However we also heard occasions when staff did not interact with the person they were supporting. On one occasion two staff were having a personal conversation which did not involve the person they were supporting at the time. One person we spoke with also commented that staff sometimes talk amongst themselves, telling us, "Staff would talk to each other, but most of the time they would ask me if I need anything. I am treated very well as a person. Not felt ignored."

People we spoke with thought the staff were kind and caring. People said, "Staff are kind and patient to me", "Staff are nice to me" and "Staff are very good, give you a lot of space. They treat me nicely as a person and safeguard my privacy."

The feedback from relatives was mixed. We were told, ""All the staff are good, kind. No one is obnoxious, or sharp." However other relatives said, "Unlike before, [name] is now getting showers OK. He gets washed and dressed in the morning, but not checked during the day" and "No organisation here. A lot of ad lib, nothing scheduled. I have found my [relative] screaming and crying in bed, and no one was attending to [relative]."

The 'Share Your Experience' forms received by the Care Quality Commission prior to this inspection also raised concerns that members of staff spent time in the office areas and speaking on their mobile phones. We discussed this with the new manager who said they had instructed staff to take their breaks in the staff room and not to stay on the units as relatives would understandably expect them to respond to any call bells or requests for assistance if they were on the unit. The new manager had also re-issued the homes mobile phone policy to ensure all staff were aware that they could not use their mobile phones for personal calls whilst at work.

The staff we spoke with were able to explain how they maintained people's privacy and dignity when undertaking personal care and support. This included ensuring people's bedroom doors were closed and people were appropriately covered. We noted throughout our inspection that the doors to people's room were often left open, even when the person was in bed. Some people may choose to have their door open as they like to see people passing outside their room. However we also saw that this sometimes meant people's privacy and dignity were not maintained as anyone passing the room was able to see the person inside. On one occasion we witnessed one person whose bedclothes had fallen off their bed and their nightclothes had risen up, leaving them in an undignified position and quite distressed. We alerted a staff

member to this who immediately supported the person to settle back in bed. We did not see any record of people's preferences for their bedroom doors to be open or closed in their care files.

People we spoke to could not recall whether they had been involved in planning their care needs. However, care records contained some personalised information which showed that people had been involved to some extent. For example, personal preferences around favourite foods were available, and in some instances information about preferred activities was recorded. The activity co-ordinators we spoke with said they were in the process of completing life story books with people and their families. They said half had been completed. However these life story books were kept in the activity co-ordinator cupboard. This meant that the information gathered about people's lives and preferences was not available for the staff team to use to engage with people in topics they know they had an interest in.

People's family members we spoke with all confirmed that they had never seen their relative's care records, or been involved in the planning of their care. One relative said, "No one has asked to talk to me about my [relative]." It is important that people and their family are involved in developing the care plans and agreeing the support people need so that the service can capture what people need and want from their support.

At the time of our inspection we were told the service did not support anyone from a different cultural background. We asked the new manager how they ensured people were protected from discrimination, including people with a protected characteristic such as disability, race or sexual orientation. The service held a policy on equality and diversity for people living at the service and the staff employed and the new manager was clear about their role in ensuring people's rights were protected. However as mentioned previously in this report, staff training was not up to date. We noted only 40% of the staff team had completed the care certificate module on equality and diversity. This meant that whilst the service had clear policies with regard to equality, diversity and human rights the staff may not be knowledgeable in this area due to the lack of training and this could have a negative impact on people living at the home.

We saw that the computer system used to record people's care plans was password protected. Any paper copies were stored in the nurse's station which could be locked when unattended. This meant that people's confidential information was securely stored.

On our return to Four Oaks on 19 January 2018 to check what improvements had been made, we observed much improved interactions between staff and people living at the service. We found staff were attentive to people's needs. One staff member sat with a person who was anxious and spent time reassuring the person. Staff were more visible on the units.

One staff member said, "There is more structure now. We are allocated to one unit so can get to know people really well." We saw an allocation sheet had been introduced on each unit which detailed who each staff member was to support.

It was too early to assess what impact that these changes have made on the quality of care and the quality of people's lives. We will look at this at our next inspection.

Requires Improvement

Is the service responsive?

Our findings

We looked at nine care plans in detail. Four Oaks uses the Care Docs computer system to record people's care plans. We found the individual care plans were brief, generic and did not provide sufficient detail to enable the care members of staff to provide person centred care and support.

For example, we found three people's behaviours were known to challenge others. We found the care plans in place did not provide clear guidance on how staff were expected to support and manage people's known behaviours safely. We observed that the behaviours of one person displaying regular behaviours which challenge were impacting on other people using the service and their individual routines. We also saw staff were struggling to support this person to manage their behaviours. We did see that some care plans, for example dementia care plans, were detailed and contained sufficient information.

Daily care records were very task focussed and gave limited details about people's well-being, such as how the person was feeling. We found there was an inconsistent approach adopted by staff when completing daily notes. We found examples of no daily notes being recorded for two people during the night shift and where daily notes had been completed, we found the time was not recorded. Other entries were identical to each other and had been 'cut and pasted' from one person to the next.

We were told that the nurses were the only staff who updated the Care Docs system. The care staff said they did not have chance to read the care plans or daily notes on the computer system.

This meant the members of care staff did not have the detailed information they needed to provide personalised support for people living at the service. This was a breach of Regulation 9 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, with reference to 3 (b).

We noted that people's wishes at the end of their lives had been recorded in their care plans. This included if they wished to remain at Four Oaks at the end of their life and if they wanted to be resuscitated. The training matrices we saw did not include end of life training for members of the care staff. This meant staff may not have the confidence and knowledge to support people as they wish at the end of their lives.

We saw that the Care Docs system recorded when the care plans had been reviewed. We noted that the plans had been regularly reviewed; however the above issues had not been recognised during these reviews. It was also not possible to establish what, if any, changes had been made to the care plans during these reviews. The Care Docs system only held the latest version of a care plan and the dates when the care plan had been reviewed. Therefore it was not possible to monitor if the reviews had taken account of any changes in people's health and wellbeing, for example a recent fall.

We observed a lack of engagement for people who remained at the service during the day. We found staff were engaged in trying to manage the day to day running of the service and thus did not have time to actively engage with people.

Four Oaks employed two full time activity co-ordinators who covered seven days per week between them. We saw that a weekly plan of activities was advertised, which included exercise classes, crafts, reminiscence and games. The activity co-ordinators told us they had received little support from the previous manager and were struggling for ideas in how to engage people living with more advanced dementia. They tried to engage people who were cared for in bed in one to one activities in their rooms. They told us they had not received any training in planning and leading appropriate activities for the people living at the home.

Care members of staff told us that the activity co-ordinators were not visible on the ground floor. During our inspection we saw an 'oomph' class being held in the large sun lounge one afternoon with seven people taking part. The activities co-ordinators told us it was difficult to get people involved as they had to support people to get from each unit to the sun lounge as the care staff on each unit did not have the time to assist them.

This meant that whilst there were staff available to arrange and engage people in various activities these were not fully utilised and supported by the home. We recommend that the service sources training for the activity co-ordinators, based on current best practice, in relation to appropriate activities to meet the needs of people living with dementia.

We saw the service had a complaints procedure in place. We saw that the deputy operations manager had completed investigations into the complaints received. This included interviewing all staff involved and looking at care plans where relevant. A reply was made to the complainant responding to each point raised in the complaint. However we saw in one response in October 2017 that it was claimed that staff training was reviewed weekly. As stated previously in this report the staff training was not up to date and the training matrix was not current. This meant that whilst complaints were looked into the responses did not always accurately reflect the situation at Four Oaks at that time. This was a breach of Regulation 16 (1) (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

On our return to Four Oaks on 19 January 2018 we found care plans had been reviewed and updated; however not all plans, for example for managing people with challenging behaviour, contained detailed guidance for staff.

Again at this inspection we observed a lack of engagement for people during the day. We noted none of the menu boards had been updated since Tuesday (our inspection was on the Friday) and no activities during the morning of our inspection took place.

It was too early to assess what impact that these changes have made on the quality of care and the quality of people's lives. We will look at this at our next inspection.

Inadequate

Is the service well-led?

Our findings

The service did not have a registered manager in post as required by their registration with the Care Quality Commission (CQC). The previous manager had applied to register with the CQC before leaving the service. The new manager said that she was in the process of completing her registration form.

Four Oaks has had a succession of managers since opening in June 2016. The operations manager explained why the previous three managers had left and these reasons were valid. However the frequent changes in manager had been unsettling for the people living at the home, their relatives and the staff. One member of staff said, "We've had a lot of temporary managers and they've not instilled the work ethic required." Some staff told us that morale at the home was low.

We looked at the quality assurance systems in place at Four Oaks. We did not see regular audits being completed, for example for care plans, accidents and incidents and staff training. Audits we did see, for example infection control and medicines had not been completed since September 2017. The medicines audits had not identified the issues found at this inspection, for example the lack of 'as required' medicines protocols. We were shown an audit completed the week before our inspection by the new manager and the registered manager from a sister home within the Kingsley Care group. This had identified shortfalls in staff training and induction and care plans not being updated on a monthly basis.

Services providing regulated activities have a statutory duty to report certain incidents and accidents to the CQC. The home were reporting incidents as required; however this was sometimes delayed as the notifications had to be approved by the operations manager rather than being sent directly from the new manager. The new manager showed us files for each recent incident with their observations and comments following each one. This system would now become formalised on the C 360 compliance programme. Prior to this we saw no evidence that incidents had been analysed to identify any trends or any interventions that could reduce the risk of a re-occurrence.

We saw that a quality manager from the Kingsley Healthcare management team had visited Four Oaks in October 2017. This was the only visit by the quality manager logged in the five months from July 2017. This identified a lack of training and staff supervisions not being up to date. In response to relatives questioning the staffing levels at the service the report notes the operational director will 'potentially increase' staff by two during the day and one at night. Actions had not been taken to address these issues and at the time of our inspection the staffing levels had not been increased.

We saw that the deputy or operational directors visited monthly, however there was no record of any formal audits or checks completed during these visits. The records state that 'issues were discussed' as well as the home's occupancy rates and training for the previous manager.

This meant the leadership and governance of the service at the location and at provider level was not effective and had not identified the issues found in this report. We found this was a breach of Regulation 17 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 with regard to 2 (a).

The new manager had held meetings with people's relatives since starting at the service five weeks before our inspection. The minutes of the meetings showed that relatives felt they had not been listened to in the past and that the communication from the home to them had been poor. The staffing levels and consequent visibility of staff was also raised. At a relatives meeting with the previous manager in July 2017 staffing levels had also been identified as an issue, with relatives stating that they were providing care for their loved ones themselves due to the lack of staff. The response from the quality manager to this was that a dependency tool was used and the home was not understaffed. This was the same response given to the GPs at their meeting in October 2017. Our observations and feedback from the staff we spoke with also showed there were insufficient staff on duty to meet people's assessed needs. This showed that despite engaging with people's relatives and the staffing levels being queried over a period of time the provider had not objectively reviewed the staffing levels.

A reliance on a staffing dependency tool was used to reject queries by relatives and local GPs about the staffing levels at the home. We found this was a breach of Regulation 17 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 with regard to 2 (a) and (e).

The new manager had also held meetings with staff members and head of departments. Concerns had been raised by the staff. The new manager acknowledged these concerns and outlined the steps that would be taken to address them. We received positive feedback from some staff with regard to the new manager. One said, "I was getting my rota week by week, now I've got a rota through to January which is a massive improvement."

We were shown a new computer system called the C 360 compliance programme. This was to be used to record all accidents and incidents, complaints and prompted when audits required to be completed, for example medicines, care plans, recruitment and infection control. This had been implemented from the 1 December 2017. We will check at our next inspection how this system is working.

On our return to Four Oaks on 19 January 2018 we saw the C 360 compliance programme was being used for quality assurance. Audits had been completed for care plans, medicines (weekly and monthly), infection control, falls and incidents, pressure area care and mattress checks and for the meal time experience. The C 360 compliance programme prompted an action plan to be completed for any shortfalls identified during the audit. The audits could be monitored and reviewed by the operations manager and central head office. This meant a quality assurance system was in place, we will check that it is consistently used to drive improvements at the service at our next inspection.

At the time of our return visit the home was being supported by the operations manager, deputy operations manager and a registered manager from another home. A senior manager from head office had spent two weeks at the home reviewing care plans and was continuing this support remotely. A new quality manager was also prioritising their time at the service.

The deputy manager had been made supernumerary to the rota to provide additional management time for the home.
We discussed the dependency tool with the deputy operations manager. The dependency tool was still showing that the home did not require as many staff as were currently on duty each shift. We queried the way the dependency calculated the number of staff needed. The deputy operations manager said that they would review it.
It was too early to assess what impact that these changes have made on the quality of care and the quality of people's lives. We will look at this at our next inspection.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care A pre-admission assessment had been completed but the initial care plans had not been written in a timely manner and staff were not always informed of people's needs through the handover process. Care plans were not detailed so members of care staff did not have the information they needed to provide personalised support for people living at the service. With reference to 3(b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had not taken reasonable practicable steps to mitigate risks to the health and safety of service users. With reference to 2 (a) (b). People were at an increased risk of choking as the care staff did not have clear information available to them about the consistency of fluids each person required. With reference to 2 (b) The lack of 'as required' medicine protocols, the time taken to administer morning medicines, missed dosages and the lack of body maps for creams.

With references to 2 (g)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs The lack of support for people to eat and the lack of meaningful fluid charts

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints Complaints were looked into but the responses did not always accurately reflect the situation at Four Oaks at that time.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing The lack of sufficient staff. staff training not being up to date meant that staff were not provided with the skills to meet people's assessed needs.

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 17 HSCA RA Regulations 2014 Good governance The oversight of the service by the managers and at provider level was not robust and had not identified the issues found in this report. With reference to 2(a) The provider had not acted on feedback form people, relatives, health professionals and staff about the staffing levels. there was an over reliance on a dependency tool to calculate staffing levels. With reference to 2 (a) and (e)

The enforcement action we took:

Warning Notice issued - The service was failing to make sure that they have systems and processes to monitor and improve the quality of the service.