Oaklands Care Services Limited

Oaklands Nursing Home

Inspection report

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21 February 2018

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection took place on the 16, 19 and 21 February 2018 and was unannounced on the first day and announced on the second and third day.

Oaklands Nursing Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Oaklands Nursing Home is registered to provide accommodation with nursing care for up to a maximum 39 people. The accommodation was split across three floors, each of which have separate adapted facilities. At the time of our inspection, there were 35 people living at the home, one of whom was staying there on a temporary basis. Some people were living with dementia.

There was a registered manager in post who was present during our inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

At our last inspection in September 2016, we rated the service at Good. At this inspection we found significant failings at the service and breaches of the Regulations.

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

than12 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.

The provider told us they do not intend to admit further people into the home until they have made the required improvements. Commissioners who fund people's care at the home are monitoring and providing support around the improvements needed.

People were not always protected from the risk of abuse and concerns of abuse were not always appropriately dealt with. People's medicine was not always managed safely or stored securely.

Risks associated with people's needs were not always accurate and up to date. The provider had failed to ensure a safe and hazard free environment. The provider had failed to protect people from the exposure to infections. There were not enough staff suitably deployed to safely meet people's needs in a person centred manner.

The principles of the Mental Capacity Act were not fully understood or followed to ensure people's rights were protected. People's nutritional needs were not always accurately assessed and monitored.

People were not consistently treated with dignity and respect and their privacy was not always maintained.

People's care plans were not always accurate and up to date and staff were not always aware of their needs and how these could be met.

There was a lack of effective leadership and governance which impacted on the quality of care and support people received. People did not receive safe and effective care because there were insufficient systems in place to ensure this. The checks the provider had in place to monitor the quality and consistency of the service were not effective in identifying shortfalls and driving the required improvements.

Staff told us they felt well supported by the registered manager and provider. Staff received basic training the provider considered essential to their role. However, they did not receive specific training to meet the individual needs of all the people who lived at the home.

People had access to a range of activities and enjoyed taking part in these. However, there was a lack of stimulation for people who remained in their rooms and they were at risk of social isolation.

The provider sought people's and their relatives views on the quality of the service. People and their relatives felt able to raise concerns with staff or management.

People and their relatives found the registered manager and provider friendly and approachable.

The provider followed safe recruitment procedures to ensure prospective new staff were suitable to work with people living at the home.

Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been 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 always safeguarded from harm or abuse.

Risks to people's health and wellbeing were not always accurately assessed and managed.

There were not enough staff effectively deployed to safely meet people's needs in a person centred manner.

The provider did not ensure a safe and hazard free environment.

The provider did not ensure people were protected from the risk of infection.

The provider followed safe recruitment procedures.

Is the service effective?

Requires Improvement

The service was not effective.

People's nutritional needs were not always accurately assessed and monitored.

The principles of the Mental Capacity Act 2005 were not always understood and consistently applied.

Staff were not provided with specific training to meet the individual needs of all the people living at the home.

The premises were not suitably adapted to meet the individual needs of the people living there.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People did not always receive care and support that protected their dignity.

People and their relatives felt staff were friendly and caring.

People and their relatives were involved in decisions about their care.

Staff provided reassurance and support when people became upset.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People's preferences were not always known and respected.

People's care plans were not always accurate and therefore staff did not have up to date information about how to meet their needs.

People and their relatives felt able to raise concerns with staff or management as they arose.

People's views and wishes for the future and end of life care were established with them.

Is the service well-led?

Inadequate

The service was not well led.

There was a lack of effective leadership and governance which impacted on the quality of care and support people received.

There were insufficient systems in place to ensure that people received safe and effective care.

The provider did not have adequate systems or resources in place to assess, monitor and improve the quality and safety of services provided.

People, their relatives and staff found the registered manager and provider friendly and approachable.

Oaklands Nursing Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection was prompted in part by concerns and complaints we had received about the service that indicated potential concerns about the management of risk. This inspection examined those risks.

This inspection took place on 16, 19 and 21 February 2018 and was unannounced. The inspection was conducted by two inspectors, a specialist adviser nurse 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.

As part of the inspection we reviewed the information we held about the service, such as statutory notifications we had received from the provider. Statutory notifications are about important events which the provider is required to send us by law. We asked the local authority and Healthwatch if they had information to share about the service provided. We used this information to plan the inspection.

During the inspection we spoke with seven people who lived at the home and five relatives. We spoke with a director, the nominated individual, the registered manager and 12 staff which included three nurses, a team leader, five care staff, the cook, the activity worker and the maintenance worker. We also spoke with two visiting healthcare professionals. We viewed nine care records which related to the assessment of needs and risk. We also viewed other records which related to the management of the service such as medicine records, complaint records and the recruitment records for five staff.

We observed care and used the Short Observational Framework for Inspection (SOFI). SOFI is specific way of observing care to help us understand the experience of people who were unable to talk with us.

Inadequate

Is the service safe?

Our findings

People were exposed to the risk of harm and abuse because medicines were not always managed safely or stored securely. We established through reading staff meeting minutes that night staff had knowingly put fluid thickening powder that was prescribed for people with swallowing difficulties into drinks for people whom it was not prescribed. Staff had reported this to the registered manager. Whilst the registered manager had discussed the seriousness of the concerns with staff at the staff meeting, they had not appropriately investigated or escalated the concerns to the Local Authority safeguarding team for further investigation. The registered manager had failed to recognise incidents of abuse and was not taking appropriate action to safeguard people from the risk of harm or abuse.

During our inspection visit, we observed that fluid thickening powder was left unattended in both communal areas and people's bedrooms. This is contrary to the National Patient Safety advice on the safe storage of the food/fluid thickening powder. Accidental ingestion of this powder puts people at risk of death by asphyxiation. We found that the label had been removed from one container of the powder and therefore staff did not have information to indicate who it was prescribed for or how much to use. This placed people at continued risk of receiving medicine they had not been prescribed or that was at the incorrect consistency. We alerted the registered manager to the risks associated with the powder. However, on the second day of our inspection we found that powder had been removed from some areas of the home but on two separate occasions we saw that it had been left accessible to people living in the home. There were people at the home who were living with dementia who liked to walk around the home independently. Because this powder was not kept secure they were placed at potential risk of harm should they swallow any of this powder. Following the inspection visit we formally wrote to the provider about this issue. They told us that the thickener powder was now locked in the medicine trolley and administered by the nurses as required.

Some people were prescribed medicine to be taken as required (PRN). We found that PRN protocols were not always assessed and implemented in line with people's needs. For example, one person was prescribed medicine to help manage their behaviour. This person's care plan identified triggers that may contribute to changes in their behaviours and directed staff to explore these prior to administering sedative medicine. The person's PRN protocol however did not make reference to these triggers. We found staff had administered sedative medicine to this person without evidence that they had first explored any of the known triggers and less restrictive approaches that could have been taken. This placed the people at risk of having their behaviour controlled by the inappropriate use of medicines. Following the inspection visit we formally wrote to the provider about this issue. They told us that a meeting had been held with the nurses to ensure they were clear about their roles and responsibilities. In addition to this the registered manager had arranged a care plan review for the person and was completing daily checks to ensure PRN protocols were being followed

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

Although staff had received training on the safe management of medicines the provider had not taken measures to ensure all staff were competent in the roles expected of them. The registered manager told us they had fallen behind with assessing nurses' competency to practice. They also did not complete medicine competency assessments for senior care staff who acted as second signatories for nurses when administering controlled drugs. Audits to check medicines were managed safely were not effective. A nurse told us they completed audits of medicines however, these were not all documented. The last medicine audit was completed in August 2017 by the registered manager. Staff were unable to provide examples of how they were checking whether people had received their medicines as prescribed. The lack of audit also meant staff did not know how many PRN medicines were being used in order to maintain stock and keep people safe.

There were building works being completed at the home. We found that the provider had not considered the risks to people and did not ensure a safe and hazard free environment. The provider and registered manager told us they had not completed a risk assessment to guide staff how to protect people from harm while building work was being undertaken.

In one bathroom that was being refurbished, we found building materials and tools which included a claw hammer, chisels and a power drill had been left unattended and accessible to people living at the home. The room also contained a tub of cleaning fluid which contradicted the provider's Control of Substances Hazardous to Health (COSHH) policy which required them to store chemicals in a locked area.

We saw a series of other hazards at the home which included poor lighting in some areas. This was of particularly concern in one corridor where there was a sharp incline in the flooring which was difficult to see in the poor lighting. This placed people at risk of trips and falls. People were also placed at risk of trips as staff had left empty boxes in the corridor which restricted the walkway. In another area of the home we saw that surplus furniture had been stacked in an alcove. This posed a risk of injury if people tried to access this area of the home.

In other parts of the home we saw that people had access to rooms which contained equipment that exposed them to the potential risk of harm if they were left unattended. For example, in the sluice room there was a machine that reached a high temperature to sanitize items of equipment. There was not a lock on the door which meant people could enter at any time. The kitchenette also did not have a lock and contained electrical items which placed people to risk of burns of scalds if left unsupervised.

We spoke to the registered manager and provider about the above concerns on the first day of our inspection. The provider told us they completed health and safety checks in the home which included checking five rooms per week. When we asked them about the hazards they had failed to identify they told us, "We hold our hands up to this." They agreed to take prompt action to address the immediate action to rectify the areas of risk. We advised the provider to take time to complete a check of the home for other possible areas of risk.

The provider took immediate action to secure areas of risk we identified on the first day of our inspection. However, on the second day of inspection we found further hazards. We found that the provider was completing refurbishment work to another room that had been left unlocked. This room had a wet floor, call bell wires hanging from the wall and pieces of plastic protruding from the walls which posed a risk of injury to people: A vacant bedroom we looked at had a sharp and uneven threshold entry into the en-suite, this room was unlocked and accessible to people living at the home. The provider had identified that the floor covering needed to be replaced in this room but had not identified the hazards of the threshold. They agreed to rectify this hazard prior to anyone being admitted to the room. In the court yard there was a piece

of rotten wood covering vents from the kitchen which posed a risk (of injury) to people should they tread on the wood. There were external maintenance workers at the home on the second day of our inspection and we saw that they had left their tool boxes unattended in reception. The provider had not followed their own COSHH policy as we found five containers of cleaning chemicals outside the COSHH shed in the court yard which was accessible to people living at the home. The registered manager and provider took immediate action to securely store the chemicals.

Risks associated with people's needs were routinely assessed, monitored and reviewed. These included risks associated with people's nutrition mobility and skin integrity. However, we found that guidance provided to staff to mitigate risk was not always clear. For example, it was not always clear how often people who were unable to move themselves needed help to be repositioned. One person's risk assessment instructed staff to reposition them every two to three hours. We looked at this person's repositioning charts and found that there were times when this person had not been repositioned for up to four and a half hours. In addition their repositioning charts did not always record the date so it was therefore difficult to establish when support had been given. Likewise this person was incontinent, which increased the risk of skin breakdown however, staff had not accurately recorded when continence care was provided. We spoke with the registered manager who said they completed spot checks on staff practice to ensure that people's needs were being met and said, "That's poor written work (by care staff)."

Some people were nursed on pressure area care mattresses as they were at risk of skin breakdown. A nurse we spoke with told us that the nurses checked people's pressure relieving mattresses were set at the correct level each day to prevent the risk of skin damage. We looked at the pressure mattress recordings for two people and found that the pressure checks had not been completed for up to 10 days. Whilst these people did not have pressure sores this meant people were exposed to risk of skin damage.

People's nutritional needs were not always accurately assessed or monitored. We looked at the records of one person who was deemed at high risk of malnutrition because of their poor dietary intake. We saw that the person would not allow staff to weigh them and that their skin risk assessment instructed staff to use their 'clinical judgement' to identify any changes. This approach was open to individual staff's interpretation and therefore an unreliable way of measuring whether the person had experienced weight loss. When we asked a nurse why they had not used an approved screening tool, such as those displayed on the posters in their office they replied, "Maybe we didn't think outside of the box." When we brought this to the attention of the registered manager they told us they had intended to look at other screening tools for this person but this had 'slipped their mind'. This meant the provider was not using current or recognised screening tools to accurately assess the person's nutritional needs. We also found that despite an identified risk of malnutrition, staff did not accurately record what the person had to eat each day. For example, when we were talking with one person we saw that they had not eaten their meal from the previous day, but that their food chart recorded that they had. The registered manager told us this person was seen and reviewed by the GP on a monthly basis but they had not referred the person to the dietician. They explained their reason for this was that the person's dietary intake was a longstanding issue prior to them starting to work at the home.

We observed staff assisting one person to move around the home in a wheelchair which did not have footplates on. This practice can expose people to the risk of falling out of the wheelchair should they put their feet down when staff were supporting them. When we spoke with the staff member about this they told us the person refused to use their footplates. The registered manager confirmed this. They told us this was documented in the person's care plan. However, when we looked at this person's care record with them we could not locate this information. Staff, therefore did not have clear guidance on how to support this person safely and the risks associated with this had not been assessed.

Staff did not always follow set protocols or take appropriate action following accidents and incidents at the home. One person had fallen and sustained a head injury. The provider's protocol for head injury required staff to complete an initial assessment to determine whether the person required emergency treatment. If not, staff were to complete neurological observations each 15 minutes for the first hour and then four hourly thereafter. If the observations were normal after 12 hours staff could stop recording. We observed that staff had stopped their observations after four and a half hours. When we spoke with the registered manager they told us staff should have continued to monitor and record their findings.

In another instance a person had fallen out of bed. The registered manager told us that staff had taken action to prevent reoccurrence and had updated the person's care plan to reflect this. However, when they showed us the person's care plan we saw that staff had reflected that the person's bedrails had been removed but did not show that staff were to instead lower the height of the person's bed and to place mattress on the floor next to the bed to reduce the risk of injury should the person fall again. This meant staff did not have up to date information of how to reduce the risk of injury to this person.

Incidents were not always appropriately recorded to enable staff to look at ways of better supporting people to manage their anxieties. The registered manager told us that staff completed behaviour charts to monitor any changes or triggers for people's behaviours. They said these charts were analysed and used by staff to inform care planning. We looked at one person's behaviour chart with the registered manager. They agreed that it had not been completed effectively and in parts was illegible. We also saw that staff had not completed behaviour charts for one person since September 2017 even though the person's care records showed that there had been numerous incidents since then.

Prior to our inspection visit we were informed that a person had absconded from the home. The provider had fitted a key coded lock to the outside door to prevent reoccurrence. However, during our inspection we saw that the code for the lock was displayed next to the lock. We spoke with the registered manager who took immediate action to remove the notice with the code from the door. In another incidence a person had managed to get up on a flat roof at the home via the fire escape stairs in the courtyard. The provider sought advice from their fire safety assessors and placed a chain across bottom of the stairs to deter people from trying to go up the stairs. We found that the chain had a clip on it that was easy to undo, this meant there was a risk that people could still access the flat roof. This showed that the provider had not taken learning from past events at the home as people were still at risk of harm.

Following our inspection visit we spoke with the fire service who visited the home and provided advice and guidance on how to make safe the fire escape stairway. The provider also sent us information to demonstrate that they had taken action to protect people from the risk of accessing the flat room via the fire escape stairs.

Relatives we spoke with were complementary about the cleanliness of the home and told us that they never experienced any unpleasant odours when they visited. However, we found the provider did not make sure people were protected from the risk of infection. When we spoke with a staff member in the kitchen we observed that they had an uncovered open wound on their arm. They told us they did not have a dressing on it as this caused them irritation but would apply one if we wished them to do so. They proceeded to scratch the wound and did not wash their hands prior to applying a dressing on the wound. Adjacent to the kitchen there was a toilet which had a notice on the door which read. "This toilet door must be kept closed at all times for hygiene." We found this door had been left open. The laundry was situated near the kitchen. There was a notice on the kitchen door instructing staff to make sure the door was kept closed while the machines in the laundry were operating. We observed that the kitchen door was left open while the machines were operating. This meant there was a risk food could become contaminated with bacteria. The

registered manager told us they last completed an infection control audit in June 2017. We saw that they had identified concerns which had been discussed at a staff meeting and actions agreed to improve staff practice. The registered manager told us they had not had the time or opportunity to complete a further audit of infection control to determine if staff practice had improved.

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

People and their relatives had mixed views about the staffing levels at the home. Relatives we spoke with were positive about staffing levels. One relative told us, "There's always plenty of staff. They deal with matters as soon as they're aware." Another relative said, "I go home knowing [family member] is in safe hands. I think they're (staff) wonderful. They're always with [family member]. They check on [family member] in their room and they have bed rails. I think they seem to have enough staff. If they (people) want something, there's someone there. I never see anyone sat there calling and waiting." Meanwhile people who lived at the home did not feel staffing levels were sufficient. One person felt more supervision was required in the lounge area as they had often seen people fall in this area. They went on to say, "The main thing is that staff don't have enough time. There just isn't enough time in the day. Income received by the home means that staffing is at about the level when it can just about cope. I have a buzzer but I use it as little as possible. I wait my turn". Another person said, "[Staff member's name] is good when I want to go to the toilet. They find someone to take me. When they are not here, I might have to wait for an hour. That's why I don't like them pushing tea and coffee all the time." A third person explained that they had a call bell to enable them to call for assistance when they were in their bedroom. They told us "They'll (staff) answer it (call bell) when it suits them. Sometimes I'm waiting ages to get dressed or get to the toilet."

Staff we spoke had different perceptions on staffing levels. Some staff felt staffing levels were sufficient and others found that they did not always get time to spend one-to-one time with people. One staff member explained they had limited time to spend with people in their bedrooms because it was so busy in the lounge areas. During our inspection we saw that staff attended promptly and calmly to people's request for assistance. For example, we heard a person call out from their bedroom because they had spilt a drink and were anxious. We saw a staff member and the registered member quickly cleared up the spillage and provided reassurance. Likewise another person expressed discomfort as they had wished to go to the toilet, a staff member promptly attended and alerted other staff to help provide assistance.

During our inspection we saw that staff were not always effectively deployed to meet people's needs and support was often task focussed. At lunch time on the first day of our inspection we saw that staff moved around the tables to assist to help people feed themselves and did not give them the individual support they required. We found that people who remained in their rooms had little interaction with staff apart from when staff were supporting them with care tasks. The registered manager told us they used a dependency tool to determine staffing levels. In addition to this had introduced a staff allocation rota for meal times to ensure people received the help they needed to feed themselves. However, we found that this had not proved effective at lunch time on the first day of our inspection.

We saw that the provider had completed personal emergency evacuation plans (PEEPs) for each person. The PEEPs identified the support people would require to leave the home safely in the event of a fire or other such emergency. A staff member we spoke with was able to tell us how they would support people to exit the building in the event of an emergency.

The provider followed safe recruitment process to ensure that prospective new staff were suitable to work in the home These included references from previous employers and Disclosure and Barring Service (DBS). The

DBS helps employees make safe recruitment choices. The provider also ensured staff were eligible to work in the United Kingdom and that the nursing staff held and maintained the requirements of their registration.

Staff supported people to move around the home safely. We saw that staff explained to people what they wanted them to do when they were helping them to move around and that they provided reassurance when using equipment to lift them.

Requires Improvement

Is the service effective?

Our findings

People's rights were not always protected as staff did not consistently apply the principles of the Mental Capacity Act 2005 (MCA). The 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). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

Staff demonstrated they understood they needed to gain people's consent before supporting them. However, we established they had a limited understanding of the MCA. MCA assessments completed did not always clearly define the decision to be made. For example, one MCA recorded 'personal care' as the decision to be made. We saw best interests decisions were referred to in people's care plans and MCA assessments without any clear direction as to what steps staff needed to take to ensure that people's rights were protected. For example, one person's care plan read, "Staff act in [person's] best interests to reduce anxiety."

We also found that best interests decisions did not demonstrate that the decision makers had considered the least restrictive option to meet people's needs. For example, we saw that one person was sometimes supported to take their medicines covertly. Covert is the term used when medicines are administered in a disguised format, for example in food or in a drink, without the knowledge or consent of the person receiving them. A nurse showed us that a MCA assessment and a best interests decision had been made to support the decisions making process. It was documented that a multidisciplinary meeting had taken place with two nurses and the GP, however there was no supporting evidence detailing when this meeting had taken place, what medicines this was in regard to, or a clear rational of evidence that they had considered the least restrictive options such as liquid medicine or altering the time the medicine was to be given.

There was some confusion amongst staff about the purpose of DoLS and which people living at the home had a current DoLS in place. Staff were unaware that people could have conditions attached to their DoLS which needed to be complied with. In one instance we saw that a condition attached to a person's DoLS authorisation read, "Specific restrictive interventions, such as [person's name] be nursed in bed when distressed, must be clearly underpinned by a robust best interest process." There was no record of such decision-making in the person's care plan, yet the person's daily notes recorded there were times that they were supported to bed when they were distressed. A condition of another's person's DoLS was for staff to offer and record what they chose to eat. However, when we looked at this person's food chart and found they lacked a varied diet and ate the same food every day. The person's food charts did not distinguish that

the person was offered or provided with a choice of soups or different foods.

The registered manager was aware of the DoLS they had applied for and had been authorised since they had been in post and knew which of these had conditions attached to them. However, they were not aware of the status or content of DoLS applications that had been submitted prior to them starting work at service. We had to contact the DoLS team to get this information. We therefore were not assured that people's rights were consistently protected.

We spoke with the registered manager about staff's lack of understanding in relation to the MCA and DoLS. They told us that they had already identified some staff lacked knowledge in this area and we saw minutes of a staff meeting where this had been discussed. They told us they would arrange additional training and support in this area to increase staff awareness in order to protect people's rights.

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

The provider did not ensure that the environment was adapted to meet the individual needs of people living at the home. One person told us they had wanted to spend time in the lounge on the first day of our inspection. When staff took them to the lounge in their wheelchair there was not a chair available for them to sit in so staff returned them to their bedroom. They told us this had made them "feel low".

We observed that communal toilets were unable to accommodate both a hoist and people's wheelchairs. Staff therefore had to hoist people from the corridor into the toilets which meant staff had to complete 90 degree turns while the person was suspended in the hoist. This increased the risk of injury to people and staff, as hoists are designed for transfers and not to travel a distance. When we spoke to the provider about this they said they would look at how they could resolve this issue. On the second day of the inspection the provider told us they had instructed staff to take people who had an en-suite back to their bedroom when they needed to use the toilet. By the last day of the inspection they had asked a company to visit to establish whether a ceiling track could be fitted in the toilet. In the interim they told us they were going to purchase a screen to protect people's dignity when they transferred them between the corridor and the toilets.

The provider was in the process of refurbishing a bathroom and therefore people had been unable to access a bath since August 2017. In the interim, people were supported to have a shower instead. We saw that the shower rooms in use were cluttered with laundry bins and other items of equipment. Staff and the registered manager told us they had to move these bins into the corridor before they could shower people. The corridors were narrow and this would cause congestion and could hamper the evacuation of the building in the event of a fire or other emergencies. We formally wrote to the provider about this issue and they told us that they had ordered the new bath and had taken action to declutter the shower rooms.

The environment was not supportive or enabling for people living with dementia. There was limited signage or points of reference such as memory boxes for people living with dementia to orientate themselves around the building independently. On the second day of our inspection we saw the orientation board in the lounge which displayed the weather and day of the week was two days out of date. This could cause confusion to people living in the home.

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

People had different views about the variety and quality of food provided. One person told us, "There's a

choice sometimes but they've (cook) been getting the menu wrong a lot. They (staff) bring you a quiche and a salad in the middle of winter. They bring you fish fingers and peas but no chips, that's half a meal." Another person said, "Cook will cook a special meal if you ask them in advance. I had smoked haddock poached in milk yesterday and today I had sea bass."

Some people required assistance to eat and drink. One person told us they had poor dexterity and that staff fitted a guard to their dinner plate to enable them eat their food independently. We saw people's lunchtime experience differed. While some people had one-to-one support to eat their lunch in a calm and patient manner, we saw that others did not receive the individual attention they needed as staff were supporting more than one person at a time. We also saw limited interaction between some staff and the people they were supporting to feed themselves. During our inspection people were offered a choice of drinks and snacks and we saw that drinks were readily available to people in both communal areas and in people's bedrooms.

We spoke with the cook who told us and showed us that they were provided with details about people's dietary and nutritional needs when they were admitted to the home. Staff notified of any changes in people's dietary needs as they occurred. They told us menu options were discussed at meetings held at the home. They also spent time talking with people on an individual basis about what they liked to eat and catered for their choice.

People and their relatives felt staff were adequately trained. A relative said, "New staff shadow experienced staff. They (staff) have ongoing training and they learn about the individual. There is a culture of care."

Staff received basic training which the provider considered essential to their roles such as, manual handling and infection control. However, staff were not provided with training to meet the individual needs of all the people who lived at the home. Three people at the home were living with Parkinson's disease. Staff we spoke with had not been provided with training in how to meet their specific needs. One staff member told us, I don't need to know (about the condition) as I'm not involved in giving the medication." The staff member was not aware how this condition could affect people's swallowing or their emotions. When we spoke with the registered manager about this they arranged for a specialist Parkinson's nurse to attend to provide training for staff.

The registered manager told us they had become part of a work force development plan, linking in with local training resources. They said they had recognised that training provided to staff did not meet the national minimum data set. They had therefore arranged for a local training provider to deliver all their mandatory training apart from manual handling and first aid which they were going to source from other agencies. Training was generally delivered face-to-face but they were also looking at eLearning packages to increase staff access to different training opportunities.

Staff told us and the registered manager confirmed, they had fallen behind with care staff supervision. These are one-to-one meetings between staff and the their line manager where they can discuss their training and development needs as well as any support they required to meet people's needs. Staff however felt that they could approach the nurses or the manager at any time should they require support or guidance. Following our inspection the provider arranged for an independent agency to provide clinical supervision for the nurses employed at the home.

The registered manager told us they assessed people's needs before they were admitted to the home. If the person was being admitted from hospital they used information provided from the hospital as well as speaking to the person and where appropriate their relatives. They regularly worked with other

professionals to promote effective care and treatment. For example, a nurse from the mental health team visited the home on a weekly visit. On the first day of our inspection a nurse was visiting the home to provide guidance on continence care. Records we looked at confirmed involvement of other professionals in people's care and support. This included speech and language therapists (SaLT), opticians and the mental health team.

Staff told us they reported any concerns about people's health to the nurse who contacted the relevant health care professionals. This was confirmed by a relative who said, "They're (staff) very good at responding to my worries. They will call the GP and then feedback to me." Another relative said, "If [family member] is poorly they (staff) ring me up immediately." They went on to say that staff kept them informed about everything.

Requires Improvement

Is the service caring?

Our findings

Relatives we spoke with felt that staff treated their family members with dignity and respect. However, during our inspection we found that this was not always the case. We detected that some people or their bedrooms did not smell fresh. When we spoke with the registered manager about this in relation to a person they confirmed this was sometimes a problem. They duly arranged for staff to change the person. On a separate occasion we smelt a malodour from the corridor outside a person's bedroom. When we spoke with a staff member this they told us they had just supported the person to change and this is why their room smelt. They went on to tell us staff should have sprayed air freshener.

At lunch time on the first day of the inspection we saw that staff discreetly asked people if they needed to use the toilet. However, staff then they proceeded to queue people up in their wheelchairs outside the toilets doors. They subsequently had to transfer the people from the corridor into the toilet with a hoist which compromised their dignity.

We saw that the daily handover sheets used to pass information between staff during shift changes referred to people with derogatory language. For example, one person was described as; "is difficult." Recordings about other people included, "dementia, ineffective communication" and "communication unreliable" This showed a lack of respect for people or their feelings. This language also labelled people and impacted on staff's perception of them. For example, one staff member told us the person who was described as 'is difficult' was difficult to engage with and did not like to talk with strangers. However, this person willingly spoke with members of the inspection team over the three days of our inspection.

Staff did not always show respect for people's home environment. We saw that wheelchairs were stored in the corridor near the lounge area. Hoist slings were hung from coat hooks outside the toilets in communal areas. On the last day of our inspection we saw that the maintenance worker was working in a room next to a person's bedroom. They had run an electric extension lead from the person's bedroom to the area they were working in to operate a tool they were using to dig up the concrete floor. They had not closed the person's bedroom door or put dust screens up and the dust caused by the works had entered the person's bedroom and settled on their furniture. This demonstrated a lack of regard for the person's personal space and property.

People's privacy and confidentiality was not always maintained. We found that folders that contained personal information about people's needs were left in the corridor, where they were accessible to visitors to the home. We saw that a pen picture for one person was pinned to the outside of the staff room door which was visible to external builders who were working in that area of the home. One staff member had taken a file containing people's personal information home to work on. They asked a relative of theirs who did not work at the service to bring this file to the home so they could show us it. This demonstrated a lack of understanding and respect for people's confidential records. Additionally people's archived personal information was stored in an unlocked room in the hairdressing salon at the home. The registered manager told us they were unable to lock this door as they did not have a key. They agreed to secure this door and had done so by the last day of our inspection.

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

Staff responded to people with kindness and compassion when they became upset. For example, on the first day of our inspection a person became anxious and started to call out. A staff member held their hand and quietly reassured them before they asked a colleague to call the nurse. A relative we spoke with said, "I think they've got very good care. [family member] gets very agitated and they (staff) go through a lot of stops to find out what's wrong. They really know [family member] and what they like, such as a quiet time in their room."

People and their relatives told us staff promoted their independence. One person told us they wanted to improve their mobility and staff supported them to do their exercises each day. They said, "They (staff) like you to use those frames for walking. It's very good. They're getting me to stand up with it." A relative we spoke with told us staff encouraged their family member to as much as they could for themselves.

On the whole people were satisfied with staff approach. One person said, "It's all very reasonable and nice really. As individuals, most of them (staff) are very nice." Relatives we spoke with were positive about the care their family members received. One person told us, "Exceptional care and very friendly. They (staff) take on the families as well. They've helped me accept what's happening. All I used to see was dementia, now I see people. Another relative said, "The staff are lovely. They're (staff) kind and treat people with respect."

People and their relatives told us they were involved in decisions about their care. One person told us that staff offered them choice of what they wanted to eat each day and about the time they wanted to go to bed and get up. A relative we spoke with told us they were involved in care planning and reviews of their family member's care. They said, "It (care plan) was reviewed with me when I noticed that [family member] was having difficulty with swallowing." Another relative told us staff also kept them informed of any changes in their family member's needs. They said, "As soon as they see me, staff come and talk to me about any concerns, such as [family member's] weight."

A staff member we spoke with recognised that people's likes and dislikes could change over time. Although they were familiar with people's routines they were always careful to offer choice. Another staff member explained they always offered people choice and explained to people what they wanted them to do. Where they had difficulty communicating with people verbally they showed people options and observed their body language to establish their views. They went on to tell us they used to use communication cards to help one person make their own decisions. This person's abilities had deteriorated but they were sometimes able to indicate their wishes by giving staff a thumbs up or thumbs down to choices offered.

Requires Improvement

Is the service responsive?

Our findings

People did not always receive support that was tailored to their individual needs and preferences. For example, one person indicated that they were not always supported by staff of their preferred gender. They said, "It depends on who (staff) is available. I take my turn." Another person said, "The staff bed-wash me every day and I have a shower once a week. I don't like using other people's showers and I dipped out today because the staff member was amenable but I shan't be so lucky tomorrow because [staff member's name] is on and they'll look in the book and see I didn't have a shower today."

We saw that there was a rota in place which indicated that people only had a shower once a week. This was confirmed by people who were able to speak with us. When we asked a staff member if people could have more than one shower a week they told us, "No they are having one shower a week." This was regardless of the people's preferences.

One person told us they had until recently shared a bedroom with another person. As the other person's health and wellbeing deteriorated they became noisy and disturbed their sleep pattern. They had asked to be moved to another room but there was not one available. The registered manager told us they made it clear to people before they moved into the home if they only had a shared room available to accommodate them. If a person's needs changed and they disturbed the person they shared with, they said they sought support from other health professionals to help them manage the situation.

We looked at the records of a person who was at risk of malnutrition. We saw that staff monitored this person's weight and had recently referred them to the GP and dietician. The person was subsequently prescribed food supplements. However, it was evident from reading this person's care plan that they were very particular about how their food was presented otherwise they would not eat it. There was nothing in this person's care plan to explain to staff how the person liked to have their meals presented to them to encourage their nutritional intake. The registered manager was able to tell us how to set the person's meals out but staff gave us different accounts. We discussed this with the registered manager who told us they would create a visual aid in the person's care plans as to how their meals should be presented to them.

People's care plans were not always reflective of people's needs and the support provided by staff. For example, while nurses were able to demonstrate a sound understanding of wound management their actions were not reflected in people's care records. There were no wound care plans in place to guide staff how to best manage the wound. Therefore it was unclear what dressings staff should use or at what intervals the dressings should be changed. This placed people at risk of not receiving effective and consistent treatment.

Staff told us they were made aware of changes in people's needs at shift handovers and if they were unsure about how to support a person they could ask the nurse. When we spoke to one staff member about a person's care plan, they told us, "The care plans are for the nurses, not the carers." The staff member was unaware of the triggers for changes in the person's behaviour that were documented in their care plan. This meant the person was at risk of receiving inappropriate support to manage their behaviours.

Since August 2016 all providers have a legal duty to meet the Accessible Information Standards (AIS). The standards set out the requirements for all providers of National Health Services care and or publicly-funded adult social care to identify, record, flag, share and meet the information and communication needs of people with a disability, impairment or sensory loss. The registered manager told us they had been made aware of the requirements of the AIS through a registered manager's network meeting. However, they had not yet had time to incorporate this guidance into people's care plans. While we found some people's care plans had clear guidance about how to communicate with people others did not. For example, one person's communication section of their care plan read, "[Person's] communication is ineffective." There was no further information to explain what this meant or what, if any options had been pursued to help the person to communicate.

As care plans were not always accurate this meant there was a risk that staff did not have access to up to date information about how to meet people's needs. We discussed our concerns with the registered manager who told us they would take action to make the necessary improvements.

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

People and their relatives told us they had access to a variety of activities. One person was dismissive about the activity of drawing around their hand and painting but went on to tell us, "Someone comes in to play draughts and chess. It's good that." A relative we spoke with said, "Activities vary – cooking, quizzes, exercises, games, for example 'whack the balloon'." Another relative explained that the activities worker asked people what they would like to do. They went on to tell us a local church choir made regular visits to the home. There was a monthly communion service and arrangements would be made for representatives of other faiths to visit if requested. A third relative told us that their family member had visual problems but was able to join in with baking and painting.

The provider employed an activity worker who was supported by a volunteer one day a week and care staff facilitated activity sessions in their absence. We saw this to be the case on the first day of our inspection when care staff conducted a scheduled 'Movement to Music' activity. We spoke with the activity worker who knew about people's individual life histories and personal preferences. They also demonstrated they had good knowledge of people's individual hobbies and interests. For example, they told us one person used to be a dress maker, so they had a box of fabrics they liked to look at and touch. We saw this person engaging with this box earlier in the day. They told us another person used to be a hairdresser and enjoyed looking through hair magazines. The activities worker was enthusiastic in their approach and had established links with a local arts workshop who had agreed to visit people at the home as part of a 10 week art and crafts project. The activity worker told us they tried to spend one-to-one time with people who remained in their rooms but found this difficult as "it's a bit full-on down here (in the lounge)." We saw there were posters advertising activities displayed at the home and that activities formed an agenda item at meetings held at the home.

We found that people who remained in their rooms were at risk of social isolation. One person told us that they sometimes listened to the local radio station. A staff member confirmed this, but added that this person had difficulty 'mastering' the radio controls. We asked the staff member if they had considered new technology which allowed voice activation of such devices, they had not, but agreed to look into options as the provider had recently introduced Wi-Fi internet connection into the home. When we spoke to the registered manager about the risk of social isolation they said they would speak to the local college to establish if any students were available to provide support.

We spoke to people and their relatives about the atmosphere at the home. While one person told us, "It's dead", relatives we spoke with were very positive. One relative said, "It's very good, very nice. I'm in and out all the time and I feel I know what's going on and I know the staff. We looked around and this place isn't the poshest but we live very near and it's (Oaklands) the most like a home, like a family, very welcoming." This view was echoed by another relative who told us, "There's a happy atmosphere. Everybody greets you with a smile. Nothing's too much trouble. You're welcome any time of day. There's nothing I would change."

Registered providers must have systems in place to capture and respond to complaints. We found the provider had not displayed their complaints process in the home. They took immediate action to rectify this when we brought this to their attention. A relative we spoke with told us they were happy to raise any concerns with staff or management and were confident that they would take appropriate action. They gave an example where they had raised concerns about staff not being respectful towards people about 18 months earlier. This was dealt with by management at the time and they had not witnessed any similar instances since. We saw that the provider kept a copy of complaints received and responses made in reception for people and visitors to view if they wished. They told us they also shared complaints with staff so lessons could be learnt.

We saw that staff had spoken with people and established their wishes for the future and end of life care. This included information about people's spiritual needs. The registered manager told us they intended to provide further training to staff in this area. We saw that this had been discussed at a staff meeting.

Inadequate

Is the service well-led?

Our findings

The service was not well led and we found multiple breaches of the Regulations. The lack of effective leadership and governance impacted on the effectiveness and safety of the care and support people received. The systems the provider had in place to monitor the quality and safety of the service were ineffective and had not identified the shortfalls we found during our inspection.

We found that staff and management were not proactive in their approach. Staff were not always clear about their roles and responsibilities and had failed to deliver effective care to people. Whilst the provider took prompt action to address immediate risks we identified, we considered this as reactive to our observations. We were therefore not assured that the concerns we had raised would have been identified or actioned without our intervention. For example, the provider did not ensure a safe and hazard free environment and had not taken appropriate action in relation to all safeguarding concerns at the home. People's risk assessments and care plans were not accurate and did not ensure staff had up to date information about how mitigate risks and meet people's needs. The provider had not ensured the safe management of medicines. This meant that people were placed at risk of avoidable harm.

The provider conducted their own environmental checks but had not identified environmental issues we had identified during our inspection. This included poor lighting, the risks associated with building works and the dangers of stacking surplus furniture in an alcove accessible to people living with dementia who liked to walk around the home independently. We were therefore not confident in their ability to identify and manage risks.

We found that the provider had not ensured there were policies and procedures in place to support all key areas of legislation. For example, the registered manager told us they did not have a policy on equality and diversity. They had not ensured staff had received the training to understand what this meant for their practice.

The registered manager told us they were working towards improving the service, but this had not yet been sustained due to the volume of work required and insufficient resources. When they started work at the home in July 2016, they found there was a lack of systems and processes in place to ensure safe care and treatment. They told us they had introduced new systems to drive the required improvement but lacked the time and support to ensure these were effectively implemented. They told us they did not have any administrative support and had fallen behind with many of their quality checks such as, infection control audits and staff competency assessments and staff supervision. The lack of infection control audits had resulted in unhygienic practice in the kitchen. Likewise care plans audits had not been completed, resulting in inaccurate care plans. The registered manager explained that both they and the nurses audited each other's care plans. They had identified that the nurses had not been fulfilling this requirement and had reminded them of their responsibility to complete this work. Records we looked at confirmed that disciplinary proceedings had been commenced. As a result of our findings the provider told us they had now arranged for the registered manager to have administrative support. They also agreed for the clinical lead to have supernumerary hours to improve clinical oversight of people's care and treatment.

The provider had systems in place to gather people's views about the quality of the service through surveys and meetings held at the home. However, we found that actions agreed by the provider were not always sustained. One person explained that staff got moved around and they felt that this was for the staff's benefit. They told us, "We have the Residents' meeting and I tell them (staff), but you can't get through to them sometimes. You tell one (staff member) and it's going alright but then they change the carer and it's back to square one." In another instance we saw that during a meeting people had requested that wheelchairs were not stored in communal areas of the home. It was agreed that wheelchairs would therefore be stored in people's rooms in between usage. At this inspection we found that wheelchairs were stored in the area that people had asked that they were removed from.

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

The provider told us they do not intend to admit further people into the home until they had made the required improvements. The provider sent us an action plan detailing how they intended to address the concerns raised and agreed to send us weekly updates on the progress made. Commissioners who fund people's care at the home are monitoring and providing support around the improvements needed.

People and their relatives knew the registered manager and found them approachable. One relative said, "Their [registered manager's] door is always open." They went on to say, "You feel relaxed in all their [registered manager and provider] company. They are very approachable."

We asked people and their relative's whether they felt the service was well led. One relative told us, "I like this new manager. I think they get it right. They don't let things pass. They know what they want. They have a good relationship with their staff and that's another reason we chose here." Another relative said, "[registered manager's name] leads from the top and staff respect them. They're fair and firm. They're making changes but it all takes time. We see the owners most days. They know all the residents' name. I wouldn't have [family member] anywhere else. [Family member] is a precious commodity in our family".

Staff told us they felt well supported in their roles. They told us they had staff meetings where they felt comfortable to raise issues and felt listened to. We saw that staff meetings offered the opportunity to discuss areas of concern and put forward ideas.

The home maintained links with the local community. The local church visited and a student from the local college came in to play games with people. Children from the local school also visited at Christmas to sing carols.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider did not ensure that people received care and support that took account of their needs and preferences.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The provider did not ensure that staff always maintained people's dignity and privacy.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The provider did not ensure that the premises met the individual needs of people who used the service.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider had not followed the principles of the Mental Capacity Act 2005 and people's rights were not protected

The enforcement action we took:

We imposed conditions on the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider did not ensure people received safe care and treatment.

The enforcement action we took:

We imposed conditions on the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider did not ensure people were always protected from abuse and improper treatment..

The enforcement action we took:

We imposed conditions on the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to ensure effective leadership and governance and this impacted on the quality of the care and support people received.

The enforcement action we took:

We imposed conditions on the provider's registration.