Eldercare (Halifax) Limited

Oakhaven 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?	**Inadequate**
Is the service well-led?	**Inadequate**

Overall summary

This was an unannounced inspection carried out on the 25 February 2015. At the last inspection in July 2014 we found the provider had breached one regulation associated with the Health and Social Care Act 2008. We found systems were not in place to ensure people were fully protected from the risks of inadequate nutrition.

We told the provider they needed to take action and we received a report on the 11 August 2014 setting out the action they would take to meet the regulation. On this visit we checked and found some improvements had been made with regard to the quality of food, however, improvements were still required to fully ensure people's nutritional needs were met. We also identified additional areas of concern.

Oakhaven Care Home is a large detached property situated in Oakwood on the outskirts of Leeds. The service offers accommodation for up to 24 older people; some of whom are living with dementia. It is fairly close to shops and public transport links into the centre of Leeds. The home has two communal lounges and a dining room. There is also parking available and gardens to the rear of the home.

There was an acting manager in post; however this person was not registered. 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

Summary of findings

persons have legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how the service is run. The registered manager had recently left the service.

People who used the service told us they felt safe and spoke highly of the staff. We saw most staff interactions with people who used the service were warm, caring and respectful.

We found staffing levels were not sufficient at all times and there was a risk that people's needs would not be met and their safety compromised. We saw areas of the home were left unsupervised at times and staff and visitors reported concerns at the staffing levels due to the dependency of people living at the home.

A number of areas in the home were unclean, poorly maintained and practices did not always promote the control and prevention of infection. A number of areas had malodours and there was no documentary evidence of cleaning schedules to show the frequency of cleaning. Some parts of the premises were not well maintained, for example, carpets were ruffled and split and paintwork was grubby.

Accidents and incidents were not monitored and responded to to ensure people's safety and prevent re-occurrence. There was no evidence to show any learning from accidents and incidents took place. We found care plans did not contain sufficient and relevant information. People were not protected against the risks of receiving care that was inappropriate or unsafe. Care records did not show any evidence of how people who used the service or their relatives were involved in developing care plans or decisions about care and support such as Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR).

Most staff knew how to recognise and respond to abuse correctly and had received training in safeguarding vulnerable adults. The management team, however, had failed to report all incidents of abuse of alleged abuse appropriately to the CQC. This did not safeguard people properly.

Records showed staff were not receiving appropriate training, support or had completed induction. The provider could not be sure all staff understood how to deliver care safely and to an appropriate standard.

People who used the service said they enjoyed the food in the home. However, there was a risk that people's nutritional needs would not be met as people's nutritional needs were not assessed properly. Systems in place did not promote people's involvement in menu planning or choice of foods.

The home provided care for people living with dementia. There was little evidence of national guidance or best practice on which the home based the care they provided for people living with dementia.

We found the service was not meeting the legal requirements relating to Deprivation of Liberty Safeguards (DoLS). It was not clear from the care plans if people had received appropriate mental capacity assessments.

People had regular access to healthcare professionals, such as GPs, community nurses and dentists. People's physical health was monitored as required.

Staff had good relationships with the people living at the home and knew how to respect people's privacy and dignity. However, there was a lack of action to address the language barrier for a person where English was not their first language. This was putting this person at risk of isolation. It was difficult to establish how staff understood the changing support needs of this person.

People who used the service said they did not have enough to do to make sure their social needs were met. Comments included; "Nothing goes on really. All there is to do is watch TV and the one in here has been broken for ages" and "I don't know what fresh air is." There were limited mechanisms in place to communicate with people and involve them in decision making or commenting on the service.

The acting manager in post at the time of the inspection was not registered with the Care Quality Commission. Staff reported that the acting manager had not been supported by the provider in this role as senior managers had not visited or checked the quality of the service very often. Records we looked at showed this to be the case.

There were not always effective systems in place to manage, monitor and improve the quality of the service

Summary of findings

provided. The management team had failed to protect people from inappropriate or unsafe care and treatment as effective analysis of accidents, incidents and audits had not been actioned.

We found multiple breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010and the corresponding Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

There were not always enough qualified, skilled and experienced staff to meet people's needs. It was not clear if the home adjusted the staffing levels in response to people's needs.

A number of areas in the home were unclean and practices did not always promote the control and prevention of infection.

Accidents and incidents were not monitored and responded to to ensure people's safety and prevent re-occurrence. The service did not always assess risks for people's safety and welfare.

Most staff knew how to recognise and respond to abuse correctly. We found that not all safeguarding incidents had been reported to the Care Quality Commission.

Is the service effective?

Inadequate

The service was not effective.

People living at the home could not be assured that staff caring for them had up to date skills they required for their role.

People who used the service said they enjoyed the food in the home. However, there was a risk that people's nutritional needs would not be met as people's nutritional needs were not assessed or responded to.

We found the service was not meeting the legal requirements relating to Deprivation of Liberty Safeguards (DoLS).

People had regular access to healthcare professionals, such as GPs, community nurses and dentists.

Is the service caring?

Requires Improvement

The service was not consistently caring

Staff engaged with people in a warm manner and were aware of the care needs of people who used the service. People said the staff they were kind and patient. People who used the service looked well presented.

There was a lack of action to address the language barrier for a person where English was not their first language. This was putting this person at risk of isolation.

Care records did not show any evidence of how people who used the service or their relatives were involved in developing care plans or decisions about care and support.

Summary of findings

Is the service responsive?

Inadequate 

The service was not responsive in meeting people's needs.

Care plans did not provide staff with clear guidance on how to meet people's needs.

There were no effective systems in place for people to express their opinions and views on the service provision.

We saw people were unoccupied and unsupervised for periods of time. There was no planned activity programme in place to ensure the social needs of people who used the service were met.

Is the service well-led?

Inadequate 

The service was not well- led.

The acting manager in post at the time of the inspection was not registered with the Care Quality Commission. Staff reported that the acting manager had not been supported by the provider in this role.

The provider had a quality assurance system in place. However, the systems in place were not effective and did not show evidence of how the service took action to improve the service.

There was no effective accident, incident and complaint analysis carried out and therefore, people were not protected from unsafe care.

The provider had informed CQC about some significant events that had occurred but they had failed to inform CQC about all reportable events.

Oakhaven Care Home

Detailed findings

Background to this inspection

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

This inspection took place on 25 February 2015 and was unannounced. The inspection team consisted of two adult social care inspectors, a specialist advisor with a background in governance 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.

At the time of our inspection there were 19 people living at the home. During our visit we spoke with eight people who used the service, two visiting relatives, six members of staff, the acting manager who dealt with day to day issues in the service, the peripatetic manager who had recently joined the service to support the acting manager, the cook and the regional manager who oversaw the overall management of the home. We spent some time looking at documents and records that related to people's care and the management of the service. We looked at six people's care records. We also spent time observing care in the conservatory and dining room areas to help us understand the experience of people living at the home. We looked at all areas of the home including the kitchen, people's bedrooms, communal bathrooms and conservatory areas.

Before our inspection, we reviewed all the information we held about the home, including previous inspection reports. We contacted the local authority and Healthwatch. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. We were aware of concerns that the local authority and safeguarding teams had. Healthwatch feedback stated they had no comments or concerns regarding Oakhaven Care Home.

Inadequate

Is the service safe?

Our findings

Some people who used the service felt there were enough staff in the home to meet their needs. However, one person said they were often told they couldn't go out as there were not enough staff. They said "I ask but the answer is always 'no, we haven't enough staff'." Another person said, "They staff don't sit and talk; they are too busy." A visitor told us, "It can be difficult to find staff, I had a hard time finding someone today to tell me where [Name of person] was. It's the same at weekends." Another person who used the service expressed some dissatisfaction and said, "I sit in this room on my own 24/7."

We saw several people chose to spend time in their rooms rather than the communal areas. No-one told us they had to wait for assistance if they required it, however, we did not observe staff visiting these rooms regularly to check on people and we did not see any attempts to include these people in any activities in the home. We saw at times that the dining room was left unsupervised when people who used the service had their lunch. Staff were busy serving meals and assisting people in the conservatory area with their lunches. They came in to the dining room on occasions to see if people were comfortable and enjoying their meals but were not in attendance throughout the meal or on hand to offer assistance. We assisted people with condiments and serviettes when they asked for assistance as there was no staff member present.

One staff member said they were a good staff team but morale was low the last few months as they had been short staffed. They said, "It takes its toll, working 12 hour shifts and short staffed." They said the dependency level of people who used the service was not taken into account and being short staffed affected their ability to properly supervise people, sit and have a chat with people and make sure people got as many baths or showers as they wanted. They also said they did not always have enough staff to provide the assistance people needed at meal times. They also said they had raised this with the provider but been told they 'just had to manage.' Another staff member said they felt there was 'never' enough staff. They said they were 'running around' trying hard to ensure people's needs were met. They told us they had recently worked a shift where they were supported by three agency staff who were not familiar with the service and this had been hard to manage.

We asked the acting manager how staffing levels were determined at the home. They said they had completed a dependency tool based on the needs of the people who used the service. This was not available at the time of our visit so we could not see the evidence of how staffing levels had been determined. It was not clear if the home adjusted the staffing levels in response to people's needs. The acting manager said there should be one senior carer and four carers on duty between 8am and 8pm and one senior carer and two carers 8pm-8am. In addition to this they said there was a cook 8am-4pm, a domestic each day and the handy person available each week day. The acting manager said they were available 7-30am- 4pm each week day. They also said care staff were responsible for laundry duties. They said, "They do it as they go along."

On the day of our visit the staff team was reduced by one carer during the morning due to sickness. On arrival at the home, the acting manager was out of the home collecting food supplies from the wholesaler. The peripatetic manager had arrived but did not know what time the acting manager was expected. We were told efforts were being made to contact staff to cover the staff sickness. We looked at rotas and saw that over the last 24 days there had been 14 occasions where they had worked without the planned numbers of staff on day shifts. On two of these days there had been times when there were only two staff on duty. The rotas also showed there were six occasions when only two staff were on duty through the night. We saw staff were very busy and worked very hard to meet needs and supervise people's safety. However, we concluded there were not at all times, enough staff to ensure people's needs were met safely and that people were properly supervised to ensure their safety. This was a breach of Regulation 22 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see the action we have told the provider to take at the end of this report.

We looked around the home which included communal areas a number of bedrooms, bathrooms, toilets and the kitchen. We saw there was adequate provision of suitable hand washing and drying facilities in all areas of the home such as communal bathrooms, kitchen and laundry. Staff said they were supplied with plenty of personal protective equipment when carrying out infection control procedures and that they had been trained in infection prevention and

Is the service safe?

control. However, we found that some practices did not promote the prevention and control of infections. For example, we found a bar of soap in one sink area. This was unclean and embedded with dirt. The acting manager could not explain why this had been left there. We saw toilet rolls were not protected by a covered fitting leaving them exposed and open to cross contamination. The home was not clean in all areas we looked. A number of surfaces were dusty, skirting boards looked grubby, there were cobwebs in one room we looked in, and armchairs had crusted food on the sides, crumbs under the seat cushions and were heavily stained. We noted malodours in some areas of the home. A visitor told us, "It could do with a spruce up, and it often smells a bit." We also saw a vase of dead flowers with dirty water in the entrance hall.

There were no cleaning schedules available to show what was cleaned and at what interval. We looked in the kitchen and found cupboards, shelves and drawers were dirty and sticky. They did not look to have been cleaned for some time. Some work surfaces and cupboard doors and shelves were chipped and water damaged, showing the bare wood which meant they were then difficult to keep hygienically clean. There was a lack of storage in the kitchen which led to clutter making it difficult to clean around. The cook said it was difficult to maintain cleanliness in the kitchen as the equipment was domestic in style and did not lend itself to the amount of catering needed in the home. They said they did not have time to clean thoroughly. We looked at the cleaning schedules for the kitchen and saw none had been completed in the last month. The cook said the acting manager took a look around the kitchen and was aware of the difficulties but said no-one from the head office ever looked at it. They said they had raised the issue a number of times regarding the inadequate style of the kitchen but did not feel anything was ever done. We referred our concerns to the local authority environmental health department. Standards for hygiene and cleanliness were not effectively maintained and managed in all areas. The processes in place did not promote the prevention and control of infections. This was a breach of Regulation 12 (Cleanliness and infection control) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 12 (2) (h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 . You can see the action we have told the provider to take at the end of this report.

The acting manager told us checks and services were carried out on the premises and equipment to make sure they met safety requirements and this included internal checks and servicing from external contractors. Certificates for gas and electrical safety were in date. We asked to see a health and safety audit; the handyperson and acting manager were unable to locate this. However, we saw weekly and monthly checks had taken place as documented on the 'Weekly and Monthly Maintenance Reports'. Checks included window restrictors, bed safety rails and water temperatures. We also saw that the fire equipment in the home was checked by a contractor in October 2014. There was an action plan in place following this but no actions had yet been taken.

When we looked around the home we saw the premises were not well maintained. A number of carpets were dirty, wrinkled and ruffled and had started to split and posed a trip hazard. Metal carpet strips had been used to hold some carpet joins down; we saw some of these were lifting at some of the door ways. We were told that carpet stretching was booked to take place the week of our inspection as a temporary solution to this and that quotes were being obtained for replacement hard flooring. We checked some of the window restrictors and found most were in the locked position as they should be to maintain safety. We found two restrictors were not locked and immediate arrangements were made to rectify this.

We looked at the systems in place for accident and incident management. We saw there had been five accidents/ incidents for February 2015 which included people who were found sat or lying on the floor in their bedroom. We did not see improvement action plans put in place and cross-referenced with the individual risk assessments and care plans, to minimise the risk of re-occurrence. Incidents had not been monitored by the acting manager to ensure effective actions were taken, such as a referral to the falls team and to monitor for any patterns or trends. This showed that an effective system was not in place to monitor incident systems and that the service did not learn from incidents, to protect people from harm.

We looked at six people's care records and found the only risk assessments in place were for the risks of choking and falls. It was clear from information reviewed that people who used the service were at risk in other areas. One person had been found on the floor but there was no falls risk assessment update or management plan in place.

Inadequate

Is the service safe?

Another person had also been found on the floor in their room and staff were asked to carry out 24 hour observations of the person in response to this. Records showed this was only done for four hours. Where people were nutritionally at risk, no assessments had been completed and where a person was identified as being at a high risk of developing pressure ulcers there was no risk management plan. These omissions in care records put people who used the service at risk of unsafe or inappropriate care.

Each care file had a personal emergency evacuation plan (PEEP). This plan should state how the person should be moved in cases of fire. The plans did not have any details of how people should be supported when evacuating the building in case of fire. The plans just stated their medical condition and medications. This meant people were at risk of harm because the service did not have the information staff needed when they had to evacuate people in case of fire.

This demonstrated a breach of Regulation 9 (Care and welfare of service users) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. A warning notice was issued.

Appropriate recruitment checks were undertaken before staff began work. These checks helped to make sure job applicants were suitable to work with vulnerable people. We looked at the recruitment process for three members of staff and saw this was, in the main, properly managed. However, we noted that references were not always obtained from people's last employer which helps to ensure satisfactory evidence of previous conduct. The acting manager was aware of this and said it was not always possible to obtain last employer references. We also noted that on the day of our visit a scheduled interview for a carer took place. The acting manager said this was to be carried out by the administrator. It was not clear if this person would be able to assess the candidate's suitability for a carer role.

People who used the service told us they felt safe. One said it was because of the people they lived with, another said, "I'm comfortable here." A visitor said they felt their family member was safe at the home, they said, "I've never seen anything that concerns me when I visit." Another visitor said, "I'm here every day and everything's always fine."

We spoke with staff about their understanding of protecting vulnerable adults. Staff had an understanding of safeguarding adults, could identify types of abuse and most knew what to do if they witnessed any incidents. One of the three care staff spoken with did not say they would report concerns immediately but that they would observe the situation and decide what to do if the situation did not change. This potential delay in reporting matters would not adequately protect people. Staff told us they had received training in safeguarding vulnerable adults. Records we looked at showed most staff had completed this training. However, some staff had been in post over a year and had not yet completed the training. We saw training was to be delivered the day after our inspection and included most of these staff.

The home had policies and procedures for safeguarding vulnerable adults and we saw the safeguarding policies were available and accessible to members of staff. However, our review of the service history showed recent safeguarding incidents had not been reported promptly to the Care Quality Commission. Systems in place were not clear and had resulted in delays in CQC being informed of the incidents. This demonstrated a breach of Regulation 10 (Assessing and monitoring the quality of service provision) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. A warning notice was issued. We saw the safeguarding log in the home which showed the matters had been reported to the local authority for investigation. There were currently four safeguarding incidents under investigation by the local authority; we will monitor the outcome of these.

We looked at the arrangements in place for the administration, storage, ordering and disposal of medicines and found these overall to be safe. We looked at the medication administration record of four people and saw all medications had been signed for appropriately to show they had been administered. We observed staff's practice during administration of medication and saw where people required support to take their medication, for example where there was a risk of choking, the staff member sat next to them and supported them until all the medication had been taken. The staff member was respectful and patient.

People's medicines were stored securely in a locked room. Records, however, showed that the room temperature and drugs fridge temperature had not always been recorded

Inadequate

Is the service safe?

daily as per the home's policy to ensure medicines were kept at the right temperature. There were no drugs that required refrigeration at the time of our inspection. There were systems in place for the disposal of medicines. We noted there seemed to be a large amount of medication waiting to be returned to the pharmacy. No explanation of why this had built up could be provided. This medication was not stored in a tamper proof container as recommended by National Institute for Health & Care Excellence (NICE) guidance which states 'medicines for disposal should be stored securely in a tamper-proof container within a cupboard until they are collected or taken to the pharmacy'. We brought this to the attention of the management team at the home.

Inadequate

Is the service effective?

Our findings

We looked at staff training records which showed some staff had completed a range of training which included moving and handling, first aid, food safety, health and safety, dementia and Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS). However, some staff still needed to complete mandatory training or refresh this training. For example, eight out of 27 staff had not yet completed training in MCA and DoLS despite three of these staff having been in post almost two years. Six out of 27 staff in the home had never completed any training in dementia and five staff had not completed health and safety training. There was no evidence of a training plan in place to make sure these training needs were met. This meant people living at the home could not be assured that staff caring for them had up to date skills they required for their role.

Staff we spoke with were positive about the training they had undertaken and said they felt it was appropriate for they work they did. We saw the provider had introduced an induction book for staff to complete as they worked their way through induction. We only saw blank copies of these and the acting manager did not think any staff had completed them. It was not clear how induction was carried out as there were no records of this.

Staff said they felt well supported by the acting manager at the home and found them approachable. They said they received one to one supervision meetings. One staff member said they had received one recently but prior to that it had been about a year since their last one. The record of supervision matrix that was available in the home showed records of supervisions that had taken place in February 2015 for some staff. No other records were available and the acting manager said they were aware supervision meetings had 'slipped.' This meant the home could not ensure staff were competent to perform aspects of their roles as they had not had opportunity to discuss them. Staff we spoke with said they had not had an appraisal of their job role for a long time. The acting manager showed us a blank copy of the appraisal form that should have been used to record appraisal meetings. There was no evidence that staff knowledge and implementation was checked following completion of specific training courses.

This breached Regulation 23 (Supporting workers) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 18 (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

When we last visited the home in July 2014 we had concerns about the quality of the food served and whether people's nutritional needs were properly met. During this visit most people spoke positively about the food and snacks available in the home. One person said, "It's like a café – you just order what you want." Another said, "It's always lovely, very tasty and nicely presented." People told us that they could ask for drinks and snacks whenever they wanted them and that they regularly did. One person told us, "I really fancied some tea and a sandwich one evening so I pressed my buzzer. It wasn't a problem for them; they even offered me different things I could have in the sandwich." The food we observed looked appetising and smelled nice.

Staff we spoke with said they felt the food on offer had improved overall but one said that at tea time there was still very little choice. On the day of inspection, the tea time meal given out did not reflect the menu that was on display. For example, the menu said soup, sausage rolls and pickled onions would be available but there was no soup, sausage rolls or pickled onions. One person stated they didn't like sandwiches and wanted something else. The staff on duty made a different meal for them.

We observed the lunch time meal in the dining room and conservatory. We were told that people who used the service preferred to eat their meals at small tables in the conservatory and did not use the dining room much. On the day of the visit, some people chose to go to the dining room. We heard these people commenting that they didn't usually get given a choice. The peripatetic manager agreed to make sure this choice was re- introduced and offered each day to people. They also said they were looking at how the lounge/conservatory could be re-arranged to give people the opportunity of eating their meal at a communal table if they didn't want to walk to the dining room.

People in the conservatory were served their meals in the chairs in which they had been sitting all morning. Everyone had an appropriate table from which to eat and we did not observe anyone having difficulty reaching or eating their food. The television remained on throughout the meal,

although there was little evidence that anyone was watching the programme. There was nothing else to provide any atmosphere or sense of social occasion around the meal. We saw people were prepared for their meals with aprons and cutlery but then had to wait 15 minutes before the meal was served. Service remained slow, with people frequently asked to 'wait' or told staff would return to them when they could. We saw staff began to assist people with their meals and then had to break off to assist others therefore meaning people's meal time support was interrupted. The meal service did not appear organised and staff were stretched in trying to provide the support needed.

We saw there were regular drinks and snacks between meals offered to people who used the service. Snacks included biscuits, crisps, yoghurts and fruits. We noted that grapes were served at the morning snack. These were still in the packaging and it was evident they had not been washed before serving as stated on the packaging. Immediate arrangements were made to rectify this.

After our last inspection of the service in July 2014, the provider told us they would be introducing menus they could display so people who used the service would know what was on offer. We saw a menu board had been placed in the entrance hall and the breakfast menu only was displayed. There was no evidence of any other menu other than a blackboard in the corridor which may have been difficult for everyone to see or access. The provider also told us after our July 2014 inspection that they would look at providing a more visual/picture menu to assist people who may have difficulty seeing or reading the written word. This had not yet been introduced.

The cook told us they were aware of people's likes and dislikes by generally speaking with them. There were no records of any meetings with people who used the service to gain their feedback on menus. The menus we looked at were from another service run by the provider. They were not the menus that the cook worked from. There were no records of food eaten kept in the service so we could not assess if a healthy, balanced diet was taken by people who used the service. We asked people who used the service whether they had any input into the menu. Most felt that they did not, however one person told us "The cook will stick his head through the door and say what you fancy today, [Name of person]." The cook told us that some people who used the service did come and speak to him about food and that he had tried to provide meals that they liked. They said they now obtained halal meat for a person who used the service but sometimes substituted this with a vegetable protein as halal meat was expensive. It was unclear if this person's cultural dietary needs were fully met.

The cook told us that a new menu was being brought in by the provider in the week following the inspection, and his understanding was that there would be laminated pictorial menus to assist people in making choice. The cook said they were concerned about the introduction of this menu. They said, "I've built up knowledge of what people do and don't like here. There are things on that menu that I know won't be popular." There was no evidence that this menu had been developed based on the likes and dislikes of people who used the service. The peripatetic manager said this menu would be adapted to suit the likes and dislikes of people in the home. It was unclear how this would be done.

People's nutritional needs were not properly assessed or responded to. We saw from records that one person had lost weight and although the care plan stated they should be weighed weekly, they had not been weighed since September 2014, two of these months the person had been in hospital. The reason for the hospitalization was due to the person refusing to eat. The care records did not show how the nutritional risks were to be managed and monitored.

We spoke with a person who needed support and encouragement to ensure they ate and drank enough. They told us they spent their time in their room, and that this was where they took their meals. We asked if staff came in and chatted or encouraged them to eat at mealtimes. They told us that they did not. We went to the person's room twice during the lunch service and on both occasions they were unaccompanied.

In all the care records we looked at people had not been weighed since September 2014. This meant people were at risk because the service had not taken steps to monitor their weight and nutrition. Where people were having their food and fluid intake monitored we saw the fluids had not been totalled so it was difficult to establish how much fluid people were taking in on a daily basis. This meant people were being put at risk because the service had not taken the correct steps to monitor people's fluid intake and protect them from dehydration.

Is the service effective?

We therefore concluded that people's nutritional needs were still at risk of not being met. This demonstrated a continual breach of Regulation 14 (Meeting nutritional needs) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. A warning notice was issued.

The home provided care for people living with dementia. There was little evidence of national guidance or best practice on which the home based the care they provided for people living with dementia. For example, promoting choice and providing support and design and adaptation of accommodation or equipment. In one of the care plans we looked at it was recorded that the person had dementia and Alzheimer's. This showed a limited understanding of dementia because Alzheimer's is a form of dementia. There was little in the way of directions to the toilet/bath/shower room. There were no directions to lead to the conservatory area. People with memory problems would have difficulty finding their way around the home because there was little signage. Due to the lack of implementation of best practice guidance the provider could not assure themselves they were meeting the required standards regarding dementia care.

This demonstrated a breach of Regulation 9 (Care and welfare of service users) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. A warning notice was issued.

The Care Quality Commission is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLS) which provide legal protection for vulnerable people if there are restrictions on their freedom and liberty. We were told that no-one living in the home was subject to an authorised Deprivation of Liberty safeguard (DoLS). The peripatetic manager said they had identified people who were possibly at risk of being deprived of their liberty and applications needed to be made to ensure this was assessed by those qualified to do so. There was no evidence that any contact had been made as yet with the local DoLS team to gain advice regarding this to ensure people's rights were protected. It was not clear from the care plans if people had received appropriate mental capacity assessments. Further work was needed by the management team to meet the requirements of the DoLS. The service used an assessment called the restrictive practice assessment to establish whether people had the capacity to make a decision. The assessments we looked at did not have any dates of assessment and they had not been signed or reviewed. It was not clear who had carried out the assessment and how they had come to a particular conclusion regarding people's capacity. We saw one person had a letter on file from their GP authorising the service to covertly put their medication in their tea. A restrictive practice assessment had been carried out, however this was not signed or dated to show it was current or gave any details of who else had been involved in making this decision in the person's best interest.

People who used the service were not always asked for their consent before interventions took place. We saw one person was told "Put your bib on" at the start of the meal service; another had an apron put on without being asked if they wanted one. We saw people had their food cut up for them without staff asking if this was what they wanted or needed.

This breached Regulation 18 (Consent to care and treatment) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

We asked staff about the Mental Capacity Act 2005 (MCA). They were overall able to give us an overview of its meaning and could talk about how they assisted and encouraged people to make choices and decisions to enhance their capacity. They spoke of encouraging people and giving people enough time to make decisions and choices. One staff member spoke of how they would support anyone who refused care or support; always explaining the risks and benefits and spoke of how they would support people in their best interests. We observed a person who used the service refused to take their medication. Staff's response to this was appropriate.

People told us they received good support to manage their health care needs. One person said, "A doctor comes and you can see him when you need to. You can see a chiropodist too." Another said, "An optician came a few months ago, I think. He tested our eyes, it's quite good really." A visitor said "I think they do the best they can; I know that they get the doctor when [my relative] needs it." When people needed specialist interventions, we saw evidence the service had referred the person to the appropriate service such as occupational therapy for assessment of mobility.

Requires Improvement

Is the service caring?

Our findings

People who used the service looked well presented, and a visitor we spoke with confirmed that this was always case with their relative. One person told us they received assistance with dressing and said that staff encouraged them to choose the clothes that they wore. One person told us that their hearing had deteriorated to a point at which their hearing aids were no longer fully effective. We asked how the staff communicated effectively with them. They told us. "If I can't hear the staff I have a pad in my drawer and they write things down for me. Lovely people."

People told us they received the help they needed and they felt staff listened to them. We saw staff respected people's privacy and knocked on doors and waited to be asked to come in before entering people's rooms. People told us they had confidence in the staff. One said, "The staff know what they are doing; no problem." Another person said, "We have the finest staff here; tip top." A visitor we spoke with said, "The care is very good."

People who used the service said they felt that staff were kind and compassionate. They described staff as "nice" and "lovely". One person said, "One lady here just walks about all day. They are so kind to her. I chose to stay living here; the staff are the nicest people I have met." We saw that staff spoke pleasantly with people who used the service when they were engaged in any task with them. They were supportive and encouraging in their communication with people, for example when offering support at meal times. We saw interactions were overall warm and respectful.

Where a person who used the service had difficulty with communication because English was not their first language this had been noted in their care plan. Little had been done to aid this person's communication. In the past a staff member had been employed who spoke this person's language. They had now left and no other translation service had been accessed. The staff used flash cards to try and communicate but said this was not always productive. We saw the person's television was on with an English news channel playing. The lack of action to address the language barrier was putting this person at risk of isolation. It was difficult to establish how staff understood the changing support needs of this person. There was no evidence the service took people's cultural needs into account. For example staff were unaware of how to assist a person to face Mecca when praying. Staff were not aware of how to ensure this person's spiritual needs were met. One staff member said "He loves his Koran." We saw there was a damaged copy of the Koran on the person's table.

Staff we spoke with said they provided good care and gave examples of how they ensured people's privacy and dignity were respected. Staff were able to describe people's care routines and how they liked to be supported. However, one staff member said they had concerns regarding the moving and handling of two people who used the service. We discussed this with the acting manager and were told assessments had been carried out and new slings for use with the hoist had been ordered. Staff said they were doing their best to encourage these people to be as independent as they could be in any transfers until the slings arrived. The care plans did not give up to date moving and handling advice or guidance for these people which meant their care needs could be missed or overlooked.

People who used the service and their relatives were not able to tell us of any involvement in care planning or reviews of care. The five care plans we looked at did not have any evidence people who used the service or their relatives had been involved in the development of their care plan.

This demonstrated a breach of Regulation 9 (Care and welfare of service users) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. A warning notice was issued.

Some people had been identified as needing a Do Not Attempt Cardio Pulmonary Resuscitation' (DNACPR) order in place. There was no evidence that the correct forms had been completed to ensure these wishes were respected. The acting manager agreed these needed to be obtained from the GP. We also saw a red sticker had been placed on the file of a person who had not been identified as needing a DNACPR order. The acting manager said this was an oversight and the sticker had been left on the file from the previous person. They agreed to remove it. The acting manager said they used the red sticker system on the file to easily identify those people who had a DNACPR order in place.

This demonstrated a breach of Regulation 18 (Consent to care and treatment) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds

Requires Improvement

Is the service caring?

to regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 . You can see what action we told the provider to take at the back of the full version of the report.

The acting manager told us some people who lived in the home currently had an advocate. We saw information on advocacy services was displayed in the home. We saw some consideration had been given to people's wishes regarding end of life care. Records showed that attempts had been made to discuss this with people who used the service and their relatives.

Inadequate

Is the service responsive?

Our findings

People had their needs assessed before they moved into the home. This ensured the home considered how they were able to meet the needs of people they were planning to admit to the home. We saw however, that these assessments had not all been filled out correctly in that some areas had not been completed and did not therefore identify people's needs fully. We also saw that some were not signed or dated so it was not clear if they were current records and still relevant.

The care plans we looked at addressed different areas of need such as health and welfare, food and nutrition, communication and respect, skin assessment, hygiene and personal appearance.

Although the care plans identified needs and support, there was no plan on how the needs would be met. For example, in relation to a physical condition, the plan just stated the person had the condition, not how the condition impacted on them and how staff should support the person. The wording in one of the care plans was confusing and was not respectful of the person. For example one staff member had written of a person, 'I don't make sense due to my dementia'. There was no evidence the person who used the service had been involved in developing this care plan and the statement made was not explained. The care plans were not always centred on the needs of the individual for example; a person's religious and cultural needs had not been recorded as a separate need or a record made of how these needs would be met. One person's care plan on hygiene said they would prefer to be supported by a male member of staff. There was no male member of staff on duty on the day of the inspection and it was not clear when a male member of staff would be available. We also saw that one person who used the service had no assessment of need and no care plan, even though they had been living at the service for a number of months. It was therefore unclear how staff would know what support the person would require and how these support needs could be met.

There were no detailed life histories completed with people who used the service. A life history document enables staff to understand and have insight into a person's background and experiences. We saw a terms and conditions contract was in the file of a person it was not relevant to. The care plans had been reviewed by staff ticking a box to say the plan had been reviewed. There was no record to show the person who used the service had been involved in the review of their care plan.

We concluded that these gaps and omissions in care records could lead to people's needs being missed or overlooked. This demonstrated a breach of Regulation 9 (Care and welfare of service users) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. A warning notice was issued.

Most people who used the service said they spent their time reading or watching television. One person said "Nothing goes on really. All there is to do is watch TV and the one in here (front lounge) has been broken for ages." Another person said, "Some things happen in the conservatory, someone comes in during the week." There was a notice on the board in the corridor which simply said "Activities". There was no further information displayed in the home on what activity was available. People told us they would like to get out more. One person said, "I don't know what fresh air is."

During the morning of the inspection we saw people in their rooms were either sitting in silence or with the television on. It was not always clear they were watching the programme. One person was reading. People in the communal areas had televisions on, though in the conservatory no one appeared to be watching what was on and no one could tell us that they were consulted about what they watched. The remote controls were under the television out of people's reach.

After lunch there was some activity in the conservatory, although there did not appear to be any plan underpinning this. Some people were playing dominoes with staff members, although we saw one game during which the staff member broke off on two occasions to attend to other people's needs. During the game there was limited conversation with the people who used the service. It was mostly regarding whose go it might be. Three people had musical instruments; two with maracas and one with a tambourine. Music was playing and the television was left on with the sound muted. We saw one person shaking a maraca for over an hour with no interaction from the staff.

There was no activity plan in place and no evidence that activity provided was based on the wants and needs of people who used the service. We saw some laminated

Inadequate

Is the service responsive?

activity cards had been produced detailing some activity such as nail painting and pom pom making. It was not clear how this activity was delivered. The acting manager said they had an activity co-ordinator who worked 10 hours per week in the service. Staff said they did not have time to engage in activities or take people out much. They said they were too busy making sure people's care needs were met.

The home was not appropriately meeting the social needs of people who lived there. This demonstrated a breach of Regulation 9 (Care and welfare of service users) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. A warning notice was issued.

People who used the service said they had individual choice at the home and their choices were respected. They were not able to tell us in detail about how they influenced or made choices in their care. People did however say they were able to choose the frequency of bathing or showering and said the arrangements suited them. One person said, "I think it's about once a week or so." Another said "I can have a shower when I want; I just have to ask the staff to help me." Most people told us they were able to choose when they got up and when they went to bed. However one person who required assistance with these activities told us "They come when they are ready; I think they'd be annoyed if I said I wanted to wait." People told us that they were offered a choice of dishes at meal times and we observed a staff member asking people which of the choices they would like for their lunch. People told us that staff were responsive to their requests for assistance. One person said, "If I press my buzzer they come running."

None of the people who used the service that we spoke with could tell us about being given information on how to complain. They all said they would feel confident in speaking to the staff or manager if they had any concerns. One person said, "I would go and see the head sister." We asked to see the home's complaints log. The acting manager could not locate this and it was unclear if any recent complaints had been made. Therefore it was unclear as to how complaints were dealt with to minimise the risk of the same issue arising in the future.

There were limited mechanisms in place to communicate with people and involve them in decision making or commenting on the service. We saw a 'residents and relatives meeting' had been held in April 2014 and were told a more recent one had taken place in February 2015. The minutes from the latest meeting were not available. Issues discussed at the April 2014 meeting included activity and the purchasing of activity equipment. The acting manager said a number of actions from April 2014 were still outstanding. These included the arrangement of trips out and arranging baking sessions. The acting manager said they had plans to introduce two monthly meetings for people who used the service. We saw these had been planned out on the calendar but were not on display in the home. People who used the service had little awareness of how they could comment on the service. One person said "I think they have a suggestion box." Another said "I don't think they have meetings. That would be a good thing; I would go if they had them." A visitor we spoke with said that they were not aware of any meetings.

This demonstrated a breach of Regulation 10 (Assessing and monitoring the quality of service provision) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. A warning notice was issued.

Inadequate

Is the service well-led?

Our findings

The manager in post at the time of our inspection was not registered. They had been appointed as acting manager since October 2014. The registered manager for the service had been supporting the acting manager by working one day per week at the home during this time. The CQC were not informed of the changes to management arrangements at that time. In February 2015 CQC received a notification to say the registered manager planned to stop or had stopped managing the service. It was not clear from the information received what the management arrangements were in the home as no additional information was supplied. We were informed at the end of January 2015 that a peripatetic manager was also providing support to the home two or three days per week. On the day of our inspection we found the peripatetic manager had been supporting the home for the last two weeks and the registered manager had left.

Some people who used the service were able to identify the acting manager and told us they saw her regularly and felt able to talk to her. One person told us "The previous manager wasn't well liked. She was cocky; I swore at her once. [Name of acting manager] is lovely, she comes and talks to me and takes me to the shops." However, another person told us "I quite honestly wouldn't know who the manager was."

Staff told us they received good support from the acting manager, that they found her approachable and she did what she could to assist staff which included working alongside them to ensure good standards were maintained. However, staff said they did not think the acting manager had been given enough support from the provider's senior management team. They said the senior managers did not visit often. Three of the staff members we spoke with told us they felt the service was not supported by senior management. They felt the service had been' left to get on with it' and didn't feel the senior management team respected the care staff. One said, "Why don't the people from Eldercare come here and show they give a hoot?" Staff also said they rarely got any positive feedback from senior managers and said morale in the home was low. When asked if they thought the staff were happy working at the home the acting manager said, "Very low, all feel let down with management, since the new regional operations manager started he is trying". We noted the acting manager had not had any administrative support in her role until mid-January 2015.

There were a large number of policies and procedures in the home to assist staff and the management team in care delivery and the running of the home. However, many of these were out of date and we were told had been for some time. The acting manager said they were currently working on getting these up to date. It was unclear if any support was given from the provider's senior management team to manage this task. We saw the safeguarding, medicines, food safety and whistle-blowing policy had recently been reviewed.

Effective mechanisms were not in place to give staff the opportunity to contribute to the running of the home. We saw infrequent staff meetings had taken place. The last meeting took place in August 2014. Issues discussed included staff responsibilities when CQC inspections took place. Staff were informed; 'these new standards mean that when they come into the building, they will no longer be going to [Name of manager], they will be coming to talk to staff on the floor. They will want to know about the resident, about your training, where all the paperwork is kept, where the cosh records are, it is all down to the staff now'. Staff were also informed 'sickness over the Christmas period will not be accepted unless you are exceptionally poorly' and 'senior staff will no longer be responsible for doing the reviews on care plans. You are now responsible for the review of care plans of the residents who you are a key worker for'. These statements did not show staff were encouraged in their role in a supportive manner. Care issues were not discussed at the meeting which meant that any key risks were not communicated to staff about people who used the service, thus care provision was not enhanced or improved.

There were limited quality assurance systems in place in the home to assess and monitor the quality of service that people received. We found no evidence to show analysis of accidents or incidents which occurred at the home had been carried out to identify if there were any patterns or trends or ways to prevent re-occurrence. The acting manager told us they could not find the complaint file/ complaint forms so we could not be sure the home responded to any concerns raised.

Inadequate

Is the service well-led?

The acting manager told us the senior carers were currently auditing their own care plans; however we saw no evidence of this. We saw a previous care plan audit undertaken by the previous home manager in August 2014 which stated "property valuables not recorded". No other actions had been identified. We were told that audits on monthly weights were carried out however the monthly audit/action plan had not started yet and we found people had not been weighed for several months. There was no evidence of an infection control and prevention audit. The acting manager said this needed to be done.

We were shown a daily walk around record undertaken by the previous home manager in August 2014 where nothing of concern had been identified. There was no evidence of senior managers auditing of the service. The acting manager had undertaken their own quality audit in October 2014. We were told this should have been undertaken by the senior management team as part of the external auditing.

The audits we saw were not effective, many were tick box exercises when checking and did not show evidence of how the evaluation had been reached or the follow up action taken by staff. There was no evidence of any 'lessons learned' and the audits had not identified the concerns we found during our visit. The acting manager said they were working on a service development plan with actions identified from previous CQC inspections and monitoring visits from the local authority. A number of improvements were noted as needed. These included; infection prevention and control audits, medication audits, care plan audits, analysis of accidents and incidents and review of staff training files. The acting manager had only recently been given the support of the peripatetic manager to work through these improvement plans and start to address them.

The service had informed CQC about some significant events that had occurred but they had failed to inform CQC in a timely way about all reportable events. People who used the service could not be confident that important events affecting their welfare had been reported in a timely manner so that where needed action could be taken by the CQC. They should have reported three recent safeguarding incidents but had failed to do so at the time of the incidents.

We concluded that effective mechanisms were not in place to assess and monitor the quality of the service. This demonstrated a breach of Regulation 10 (Assessing and monitoring the quality of service provision) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. A warning notice was issued.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing The provider did not make appropriate steps to ensure that, at all times, there were sufficient numbers of suitably qualified, skilled and experienced staff deployed to meet people's health and welfare needs.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent Before people received any care or treatment they were not asked for their consent and where people did not have the capacity to consent, the provider did not act in accordance with legal requirements. Applications for the Deprivation of Liberty Safeguards had not been considered for people whose liberty may be deprived.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010 Cleanliness and infection control Standards for hygiene and cleanliness were not effectively maintained and managed in all areas. The processes in place did not always promote the prevention and control of infections.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing People were cared for by staff who were not supported to deliver care and treatment safely and to an appropriate standard.

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	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services The provider did not take proper steps to ensure that each person was protected against the risks of receiving care or treatment that was inappropriate or unsafe. People did not have their social needs met.

The enforcement action we took:
Warning notice issued.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service provision The provider did not have an effective system in place to identify, assess and manage risks to the health, safety and welfare of people who use the service and others.

The enforcement action we took:
Warning notice issued.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA 2008 (Regulated Activities) Regulations 2010 Meeting nutritional needs People were not protected from the risks of inadequate nutrition and dehydration.

The enforcement action we took:
Warning notice issued.