Oaklands Care Home Limited

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Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 16 October 2017 and was unannounced.

Oaklands Care Home provides accommodation with care for up to 14 older people. Care is provided over two floors. At the time of our inspection there were 13 people living at the service

A registered manager was in post at the service. 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.

Risks to people's health and well-being were not fully recorded or followed so that they could be managed safely. Professional advice was not being followed in relation to a person's nutrition.

The service did not have in place a process for the safe recruitment of staff. Staff were being recruited without the required employment checks in place to ensure they were able to work with people in a social care setting.

Training had not been developed to reflect the deterioration of people and staff did not always demonstrate they knew how to provide the right care.

We recommended that the provider develop their training with reference to a reputable source around dementia care and best practice within care homes.

Systems were not in place to make sure the rights of people who may lack capacity to make particular decisions were protected.

People were not always treated with dignity and respect and their independence encouraged. Care was not always person centred to meet their needs.

The quality assurance audits were not sufficiently robust to ensure that people received a service which met their needs and protected their safety.

There were sufficient numbers of care staff to care for people at the service.

People's physical and mental health needs were assessed, monitored and met in order for them to live well. The service worked closely with relevant health care professionals. Generally, people received the support they needed to have a healthy diet that met their individual needs.

People were cared for by staff who knew them well. People and their relatives were able to raise concerns

and give their views and opinions and these were listened to and acted upon. The registered manager was not aware of the requirements of the Accessible Information Standard but, however, they were meeting people's sensory and communication needs.

The registered manager was visible in the service and worked well together with a consistent team of staff. People were cared for by staff who were enthusiastic and supported.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Risk assessments were not fully completed and followed.

Staff were not being recruited safely in line with current requirements

People were getting their medicines safely and as prescribed.

There was enough staff to meet people's needs and staff knew the correct procedures to safeguard people.

Is the service effective?

Requires Improvement

The service was not always effective.

People's rights to consent to their care were not always protected.

Staff were trained and supported and had the skills and knowledge to meet people's needs.

People enjoyed the choice of food they were given and had their nutritional needs assessed.

People were supported to access health care professionals.

Is the service caring?

Requires Improvement

The service was not always caring.

Staff did not always treat people with dignity and respect.

People's communication needs were met and they were encouraged to express their views.

People's end of life care was discussed and recorded sensitively.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People were not always involved in the review of their care and their needs and preferences were not always met.

People and their families knew how to make a complaint and all complaints had been dealt with appropriately.

Is the service well-led?

Requires Improvement

The service was not always well led.

The quality assurance process was not sufficiently robust to ensure that the service was safe.

The registered manager had not kept up to date with current good practice.

The registered manager was visible in the service. Staff were supported and worked well as a team.

People's views were listened to and actions taken to improve the service.

Oaklands Care Home Limited

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 was an unannounced inspection carried out by one inspector on 16 October 2017.

Before the inspection we reviewed the information we held about the service. We looked at information received from and about the service since the last inspection and any statutory notifications received from the provider. A statutory notification is information about important events which the provider is required to send us by law. We considered this information when planning our inspection to the service.

The majority of people who used the service were unable to use verbal language to communicate with us. We used observation as a main tool of understanding people's experience of using the service and the care that they received. We spoke with four people who used the service, and four family members and friends. We also spoke with the registered manager, three care staff and a visiting healthcare professional.

We looked at a range of records including four care plans, five recruitment files, complaints and incidents, medicine records and quality assurance audits.

Requires Improvement

Is the service safe?

Our findings

Risks to people's health and well-being were not fully recorded or followed so that they could be managed safely. For example, in one care plan, a person's risk of falls and malnutrition had been assessed but there was no information pertaining to how these risks could be managed or reduced. Also recorded was that the person 'wandered off' and 'needed to be occupied at all times.' However, information for staff in how to support the person and manage the risks were not identified. Some records also were not dated to understand people's up to date needs, for example there was a risk to a person self- harming which was not dated. It was hard to know whether this was a current risk to the person's well-being.

One person who was at risk of malnutrition had had a number of professional assessments of their needs. However, it was unclear from the care plan as to what was the most up to date advice from the dietician. The registered manager found the most recent advice for the staff to follow which included that the person needed food and drinks which were fortified and high in calories to help them put on weight, such as full fat milk and cream added to drinks and meals. However, food and fluid charts did not reflect that the professional advice and guidance was being followed by staff and the registered manager could not demonstrate if the person was being offered or provided with the recommended high calorie nutrition or hydration.

Staff and the registered manager had a good understanding of safeguarding and what they might do if they suspected or saw abuse had taken place. However they had not applied this when considering if people were safeguarded through risk assessment. For example to enable them to remain independent and that their nutritional, physical and mental health was being adequately considered.

People did not spend time in a meaningful way but there were no risk assessments in place to demonstrate that staff recognised isolation and how lack of mental stimulation could impact on someone's wellbeing. As a result staff followed a task led process rather than a person centred approach. The lack of consideration of individual needs was not reflected in risk management at the service.

The registered manager had not considered or taken into account people's views and decisions about how any risks could be managed to ensure their independence, freedom and choices were maintained. We did not see in the reviews of people's care plans that they or their representatives had been involved in making decisions about the risks to their health and well-being.

This is a breach of regulation 12(1)(2)(a)(b)(i) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider did not have a robust recruitment processes in place which kept people safe. Of the five recruitment files we looked at, we found that in three of them, a full employment history had not been obtained from the person as per the legal requirements. Without checking thoroughly the reasons for any gaps in employment the provider could not demonstrate that the person was suitable for the role.

We noted in two of the files that there did not contain any professional references about previous experience and, in one of the files, references were from family members. In another file, references had been obtained from professionals who lived at the same address as the person but these had not been signed. The registered manager had not checked that these were authentic and from the professionals specified.

We were not assured that all staff were recruited safely and all the necessary checks were in place.

This is a breach of Regulation 19(2)(3)(a) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 .

People and their relatives told us they were safely looked after. One person said, "They have been very good to me and helped me settle in." A family member told us, "[Relative] is always well cared for and very safe here." Another family member said, "We have no worries about the care for [relative], they have been here a long time and we wouldn't change it."

Staff were encouraged to raise safeguarding concerns at any time and told us that this was always discussed, if for example, someone had an unexplained mark or someone was unhappy. One staff member said, "We work very closely with people, so we know them so well, we would know if something was not right and look into it." The registered manager told us that they currently had no safeguarding concerns at the service. However we remain concerned that staff and the registered manager did not recognise that people's deteriorating condition put them at increased risk. The link between this and keeping people safe had not been identified and therefore there were significant opportunities lost to safeguard people's well-being.

Assessments had been completed when people first went to live in the service. These included risks to people's health and well-being and we saw that risk assessments had been completed for moving and positioning, mobility, falls, eating and drinking and those who were prone to pressure ulcers. Specific instructions about the care and support people needed about pressure ulcer care were provided by professional nursing input. We saw a system was in place for checking people's weight and recording any loss or gain in order to manage the risks to people's health and wellbeing.

Staff had an understanding of the risks that people faced and ways in which these were managed. We saw them using equipment safely for people to move and transfer from one place to another. People could access all parts of the service and there was a lift available to the second floor. People were supported and encouraged to walk with their frames and assisted to their rooms should they need the support of someone with them. This promoted their independence and assured them that they were safe from falling.

The provider kept up to date with the health, safety and maintenance of the building and the equipment within it in order that people lived in a safe environment. They had consulted relevant bodies to ensure they were up to date with current guidance such as the food safety authority and had a food hygiene rating of five stars.

There were sufficient staff on duty to meet people's care needs. People told us that staff were available should they need them and we observed that staff were usually in close proximity to the lounge area where most people sat. The rotas were completed in advance and holidays and sickness were covered by existing staff. The registered manager also worked full time providing care and support. Staff told us they were happy to cover for each other, one said, "We work as a small team and don't need agency staff."

Medicines were given to people in a safe and appropriate way. We observed a senior care staff administering

medicines at lunchtime. We saw that medicines were handled in a safe and hygienic way. For example, gloves were used when handling medicines and their hands were washed appropriately.

People were given their medicines in a dignified and gentle way and were helped to take them where necessary. Where a person required their medicines to be given in a certain way, for example crushed in order for them to swallow it, the person's GP had authorised this process. The correct procedure for the dispensing of medicines which needed two signatures was completed correctly and in line with the requirements.

Medicines were received, returned and safely stored in a locked trolley and administered from the trolley. There were appropriate facilities to store medicines that required specific storage and temperatures were recorded to ensure that medicines were stored as required.

The records relating to medicines were completed accurately and stored securely. People's medicine administration records (MAR) had their photograph and name prominently displayed so that staff could identify people correctly before giving medicines to them. This minimised the risk of people receiving medicines which were not prescribed for them.

Where medicines were prescribed on an as 'required basis', written instructions were in place for staff to follow. This meant that staff knew when 'as required' medicines should be given and when they should not. Information was available for staff about each medicine, what it was for and what it did. This provided knowledge and understanding about the appropriate use of medicines.

The provider had received a visit from the local pharmacy who had completed a check on the administration of medicines at the service. The registered manager told us that this had helped them to audit their medicines so that the process was safely managed.

Requires Improvement

Is the service effective?

Our findings

The Care Quality Commission (CQC) monitors the operation of the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS) which apply to care homes. People can only be deprived of their liberty to receive care and treatment when this is in their best interest and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called 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.

Systems were not in place to make sure the rights of people who may lack capacity to make particular decisions were protected. We saw that capacity assessments had not been completed for everyone who needed them in the care files we looked at. Those that had been completed had not been reviewed in line with good practice and guidance. For example, in two files we saw that capacity assessments were dated March 2015 in one and November 2015 in another. In the care plan review, it was noted that there was 'no change' but no up to date assessment had been completed with the involvement of the person or their representative.

We saw that MCA assessment forms had been completed incorrectly in that decisions about capacity for five individual tasks such as washing and showering, dressing, eating, and nutrition were all assessed together rather than individually. This also included consent to medicines being given to people. This meant that there had not been consideration of the individual's right, capacity and ability to make individual choices and decisions in these areas. We saw in one person's file that agreement had been given by the GP to the person having their medicines crushed as they had difficulty swallowing. We did not see any specific MCA assessment completed to ensure that this was in their best interests.

For one person who did not have capacity, we saw that they had a Lasting Power of Attorney (LPA) in place. For another, they were supported by Essex Guardians, (part of Essex County Council) who made decisions on their behalf. However, in the three other files we looked at it was unclear who made decisions in their best interests. Consent to the sharing of information about people had been signed by one relative who had LPA but others were left blank and not signed by anyone.

The registered manager told us that they had not made any applications for DoLS as no-one in the service was deprived of their liberty or wanted to leave the service. However, there were people who lacked capacity to consent to their living arrangements and were subject to continuous supervision and control, and not free to leave the service. In our discussions with the registered manager and senior staff they were not up to date with the requirements of the MCA and DoLS. We have shared this information with the local authority who monitor these arrangements.

This is a breach of Regulation 11(1)(3) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff had the basic skills and knowledge for their role. They were clearly committed to the service and were

positive about the registered manager. However people in their care had varying different needs due to their vulnerability, age and frailty. Training had not been developed to reflect the deterioration of people and therefore staff, although intuitively kind, did not always demonstrate they knew how to provide the right care. For example we saw that staff were not up to date on how to support people living at various stages of dementia. This also meant they did not recognise when their approach to care may not have been appropriate or reflecting recognised best practice.

We recommend that the provider develops their training with reference to a reputable source, around dementia care and best practice within care homes. For example, the guidance, guidelines and resources provide by the Social Care Institute of Excellence (SCIE), the National Institute for Clinical Excellence (NICE) for dementia care and specialist organisations such as the Alzheimer's Society.

We saw from the range of certificates in their personal files that staff had received training including moving and positioning people, administration of medicines, safeguarding adults from abuse, food hygiene and fire safety during 2017. The registered manager utilised the services of an external trainer who delivered specific and up to date training for staff in the care sector. Training was done face to face as well as staff completing courses online and covered the subjects staff needed in order to work with people who used the service. Training was planned in advance with health and safety planned for November 2017 and a range of other subjects monthly until April 2018.

The registered manager had put in place a process for staff to work through and complete the Care Certificate. The Care Certificate is a recognised set of minimum standards that social care and health workers should work within in their daily lives. The Certificate was completed during the induction process for new staff or for staff who did not have a recognised qualification in health and social care.

The staff told us that the registered manager spoke to them about training they thought they needed. They said, "We discuss what's needed to be updated so we keep up with the requirements." Another said, "I feel I can say if I need anything specific and it would be organised."

Individual supervision took place approximately every two to four months and we saw that discussion about performance and practice took place. Any actions were agreed by both parties. Staff meetings were not held regularly but meetings of the senior staff were held and the notes of these meetings were shared with staff to read and sign to say they had read and understood them. We also saw that annual appraisals had been completed for all staff which noted their work and achievements over the year.

Spot checks of staff were undertaken to look at their competence in carrying out their role. We saw that staff had been observed providing personal care, moving and positioning people and giving medicines. This ensured that staff were competent and skilled in carrying out their role.

People, their friends and relatives told us that they received care which met their needs. One person said, "The staff know me inside and out." Another told us, "They are very caring to me." Family members told us, "[Relative] is well looked after and gets the care they need," and, "I wouldn't move them now I think they are as happy here as anywhere," and, "[Name] has been here a long time, they are settled and staff know them well."

People received care and support from staff who knew them well and were aware of their needs and individual personalities. Staff spoke with people and asked how they were and if they were okay. We saw that staff members used people's preferred names when talking with them and when referring to them in conversation with other staff. The use of familiar terms meant that people knew when they were being

spoken to and were able to respond back in their own individual way.

The service had a dining table in the lounge and conservatory. A staff member told us that everyone chose to eat at the small table by their seats and did not usually go to the table. We did not observe anyone being asked if they wanted to sit anywhere else. People told us that the food was, "Very nice, I like it," and, "Not sure what it was but it was lovely and warm," and, "Nice food, just the right amount." The atmosphere at lunchtime was quiet and relaxed.

At lunch and tea time, people were supported to have a healthy and balanced diet as well as have food of their choice. People's drinks were replenished often so they had sufficient hydration. Staff told us that snacks and fruit were available and kept in the kitchen and these were offered regularly, although we did not observe this on the day of the inspection.

We observed that people were assisted to eat by staff members who sat with them on the same level and made eye contact. Most staff communicated with people around lunchtime, helping to cut their food up and reminding them of what they were having. People were not rushed or hurried.

The staff took turns on a rota basis to cook for the day. Two options were available. On the day of the inspection, the board in the lounge told people that beef burgers, vegetables, mashed potatoes and lasagne were on the menu. However, the lasagne wasn't available as staff told us that nobody had wanted it. One person told a staff member they only fancied rice pudding for lunch and this was provided for them. We saw that one person was having a bowl of soft food and the staff member told us what it was and said the lunch had been liquidised together as the person could not swallow very well. People were encouraged and prompted to have dessert which people enjoyed.

When risks relating to swallowing, choking and malnutrition were identified, the registered manager told us that people were referred to relevant health care professionals such as the dietetic services or the speech and language team. We saw evidence of involvement in the care files.

People's day to day health needs were met through on-going assessment and the involvement of clinical and community professionals. These included the GP, district nursing service, dietician, chiropodist and optician. On the day of our inspection, the GP had visited a person who was unwell and provided advice and instructions for staff to follow. We also saw examples of professional visits being made to meet individual's needs and people attending hospital and other appointments. A visiting health professional told us, "We come out whenever called. They always follow our advice and provide appropriate care to people."

Requires Improvement

Is the service caring?

Our findings

Some staff showed intuitive kindness and respect and promoted people's dignity. However, we saw times when this was not always the case or put into practice and people's experience was not always consistent.

The pattern of work in the service meant that time staff spent engaged in a meaningful way with people individually was not always evident unless they were undertaking a task, such as giving them a drink, assisting them to go from one place to another, completing personal care tasks and assisting people at mealtimes. Outside of these times, people sat with very little to do, were under-stimulated and, in some cases, isolated from social activity and engagement.

Opportunities were missed to engage positively and break up the routines of the day. For example, we observed that one staff member did not talk with people appropriately at lunchtime, for example a new person to the service said, "I usually have a glass of wine with my lunch when I am at home," and the staff member abruptly said, "You are not allowed wine," and walked away. For another person who needed assistance to eat, they did not talk with a person before they offered the spoon to their mouth or tell them what they were having for lunch. We asked why their meal was not separated out so the person could see what they were eating and the staff member told us, "They wouldn't know what it was."

Staff spoke with people whilst they moved around the service but very little time was spent actually with people on a one to one basis. Two people we observed in the morning were asleep for at least two hours without any contact from a staff member. One person who was new to the service was left without company, interaction from staff or anything to do for periods of time. When they got upset, a staff member sat with them for only a few minutes reassuring them but not taking the opportunity to listen to them and find out a little about their life and background.

People sat in the same seats throughout the day unless they went to their bedroom for a lie down or to the toilet. One person who was mobile was encouraged to walk with their frame from one place to another however, they were not enabled to undertake any activity around the service to increase their independence but sat with a table in front of them with nothing to do for most of the day. When we asked how often people went out, we were told, "They don't, unless a relative takes them out or the activity worker occasionally."

This is a breach of Regulation 10(1)(2)(b)of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Despite this, people and their families told us that the staff were kind and caring to them. They said, "Lovely people look after me," and, "They seem nice, I am just getting used to them." A family member told us, "They do all what they can, but it's very hard." Another family member said, "My [relative] really likes it here and that's the main thing."

The approach was inconsistent because we also saw some positive interactions between people who used the service and staff. In these cases, staff were affectionate, warm, buoyant and used humour appropriately.

Staff were knowledgeable about people's needs and personalities as many people had been at the service for a number of years. Positive caring relationships had developed between some staff and people who used the service and those staff spoke with warmth and affection about the people they supported.

People's sensory communication needs were assessed. The information about their sight, hearing and how they preferred to communicate was recorded, for example for someone who was deaf, they preferred the use of writing on a pad to communicate. We discussed with the registered manager the Accessible Information Standard. They told us they would ensure that people's on-going communication and information needs were always met in line with the requirements.

People were dressed appropriately for the time of year and in outfits which were clean and colour coordinated. Staff were aware of the need to maintain people's appearance, for example people wore slippers to ensure their feet were kept warm. A family member told us, "My [Relative] is not bothered about their appearance anymore but the staff make sure they are dressed nicely."

We saw that people's preferred place of care, their end of life care and funeral wishes were discussed with them and their families when it was appropriate to do so. This information had been recorded so that their wishes could be carried out respectfully. We saw that decisions had been made about whether a person wanted to be resuscitated in the event of an emergency and Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) had been put in place and authorised appropriately. This information should however be placed more visibly at the front of the care plan so that staff and visiting paramedics could access this quickly to ensure people's rights would be respected should resuscitation be needed.

People's information was kept confidential within the service.

Requires Improvement

Is the service responsive?

Our findings

People or their representatives were not always involved in the reviews of their care plans. The registered manager told us that they reviewed people's care plan themselves but did not involve the person directly as most would be unable to contribute and it was sometimes difficult to get their relatives involved.

We saw that the review covered all areas of the care plan and in some sections just said, 'no changes'. When we looked back at one care file to see what their needs originally were, there was a care plan for 2012 and part of a care plan for 2014. In other care plans, we saw they were disorganised, with old and current information mixed together. We had to ask the registered manager to go through some of them with us to understand people's up to date needs. We discussed this with the registered manager who told us that they were in the process of changing the layout to make it easier to read.

Apart from one time in the afternoon when two staff sat and talked to each other and a person using the service, we did not see anyone engaged in any meaningful and stimulating activity. We saw one person get up from the chair and walk around into the office. The staff member responded by bringing them back and sitting them back in their chair saying, "There you go [Name of person] we wouldn't want you getting into any trouble."

We did not observe anyone being offered something to do, watch or listen to. There were no magazines, books or games visible in the lounge area where most people sat. The majority of people at the service were living with dementia. However, the provider did not have any resources available to stimulate and engage with people with dementia.

We saw in one person's care plan that their particular likes and interests had been recorded which included knitting and gardening amongst their hobbies. When we asked the person where their knitting was, they replied, "I am not sure, I love knitting." When we asked the staff about the person's knitting, they were unaware of this person's interest and said, "I didn't know they liked knitting."

The service employed an activity worker three times a week in the mornings. We looked at the activities records from July 2017 and found that two sessions were recorded in July, 'Walked in garden,' and, 'Had chat with [name of person] and held their hand and went to park with [name].' Only one session was recorded in August, 'Had a chat with [name of person].' There had then been a gap of three weeks before the next session. Five sessions had been recorded in September where activities had taken place with those who could participate. We did not see any records which told us that staff had undertaken any activities to replace those sessions where the activity worker was not at the service.

This arrangement did not appear to meet the mental and psychological needs of people who used the service. We discussed our concerns with the registered provider and senior staff member and they agreed to consider what they could do about this situation to get better outcomes for people.

This is a breach of Regulation 9(1)(3)(a)(b) of The Health and Social Care Act 2008 (Regulated Activities)

Regulations 2014.

The care records we looked at showed that an assessment of people's needs and circumstances was completed in order to be sure that the service could meet them. A plan of care was put in place so that staff knew how to meet their immediate needs.

A background history and personal profile about the person was completed and was written in a respectful way. The care records and risk assessments we saw contained the person's personal care routine, their mobility and any risk of falls, equipment used, nutrition, mental health and their social and leisure activities. People's likes, dislikes and preferences were taken into account for food, drink, what time they preferred to get up and go to bed, socialising and activities. Gender specific care had not been recorded in the care plans we looked at. We were told by the registered manager that no-one at the service had any needs relating to their culture, gender, ethnicity or sexual orientation. People's religious needs were met by the provision of a church service monthly.

One family member said, "There is no use asking my [relative] about things to do as they do not want to do anything." Another said, "I think they have enough to occupy themselves and the staff chat to them."

The records of people's daily life contained information about what they had done that day, how they had slept, any social or leisure activities, their mood and behaviour and any visits by professionals or family members. This information provided an important record in order to monitor people's health and wellbeing. This feedback described people's day to day lives minimally but adequately and this formed part of the hand over from one shift to another to ensure all staff were aware of people's day and night needs.

People were supported to maintain contact with their friends and family. Relatives told us they were able to visit at any time and were always made welcome.

There was a policy in place for dealing with any concerns or complaints and this was made available to people and their families. Families and friends told us they knew who to speak to and would not have any hesitation in making their views known. They also told us that they were assured that any complaints or concerns they had would be dealt with quickly and with an apology. One relative said, "They are very good, things are done before it gets to a complaint."

We saw that the registered manager had records of five complaints since the last inspection in 2016. These had been dealt with quickly and appropriately.

Requires Improvement

Is the service well-led?

Our findings

People's relatives and the staff told us that they thought the service was well led. However, there were some improvements which needed to be made.

There was a quality assurance system in place with audits being undertaken to assess and monitor the service but not sufficiently enough to ensure people were kept safe. We found that audits on the recruitment of staff were not being completed and staff were being employed without all the safety checks in place. We also found that care plans were confusing and disorganised and needed attention despite an audit which had been completed.

People's need for stimulation and meaningful activity had not been met and had gone unnoticed by the staff and the registered manager.

Whilst the registered manager had utilised some guidance to help them fulfil some of their responsibilities, such as the Care Certificate, they did not measure and review the delivery of care against current guidance. This included MCA and DoLS, dementia care awareness, nutrition and the guidance relating to the requirements of the Health and Social Care Act 2014. We discussed this with the registered manager who told us that they did try to keep up with the guidance and were aware of the NHS Constitution which they had looked at.

Many people had lived at the service for a number of years. The registered manager had maintained the service as it was for people who were active but since many people were now living with dementia, the service had not progressed with the changing needs of the people. For example there was nothing in the service that made it accessible and friendly for people with dementia. Staff had also not been given the necessary skills and training in order to meet people's changing needs.

The staff told us the service did not have many links with the local community apart from a vicar from the church coming once a month. People did not attend any centres or activities in the community. The registered manager had not taken advantage of the wealth of support and information available within the community to increase people's participation and reduce social isolation.

Whilst there was a records management system in place, the majority of information was on paper and hand written, not always legible or easy to read.

The service did not have adequate systems in place to support the registered manager to ensure that they had effective oversight in place. Without this, the quality of the service was significantly impacted. People, staff and others were at potential risk. Opportunities had been missed to independently identify shortfalls and address them in a planned and coordinated way.

There was no overall development plan in place for the service which clearly set out how it needed to improve and what the focus should be for continual learning. Without these systems in place, people cannot

be confident that their care will be of the best quality and their health and well-being needs will be appropriately met.

This is a breach of regulation 17(1)(2)(a)(b) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Good Governance.

The registered manager was supported by two senior staff members, day and night care staff and two domestics. The registered manager worked on the rota and was visible around the service. People and their relatives all knew who they were. Staff told us they valued the registered manager and felt supported by them. They were motivated and enthusiastic about their work and knew what was expected of them. One said, "We are always listened to and our views respected." Another said, "We work as a team really, training, support or anything is provided, there's never a problem."

Despite the shortfalls in governance around care provision, the registered manager had undertaken a range of audits on the delivery of care and maintenance checks for people's safety. These included fire safety equipment, hoists and slings, window restrictors', lighting and a new boiler had been fitted in September 2017. Falls and medicine management audits were all up to date.

A survey of professionals was undertaken in July 2017. One healthcare professional said, "The care is very good they encourage the service user," and another said, "Good interaction with staff, caring attitude."

Given this feedback we considered that the improvements needed would be welcomed by the staff team who were committed to the service and the people living there.

Meetings with people who used the service were yearly and the last one was in September 2017. One person commented about the menu and action was taken to provide choice and another about going out more (which was evidenced that this had happened in one of the dates of the activities). Results from random surveys in 2017 were positive about the care being provided. One person said, "Care was good." A family member said, "I feel very happy with [relatives] care and have no complaints."

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	Regulation 9 HSCA RA Regulations 2014 Person-centred care People did not receive a service which was person centred and encouraged their independence.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect Staff did not spend quality time with people and treat them with respect.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The service was not following the requirements of the Mental Capacity Act 2005.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risks to people's health and wellbeing were not being managed safely.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The service did not have sufficiently robust audits in place and did not use current

guidance and good practice to ensure people had a high quality service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed Staff were being recruited without the required employment checks in place.