Care Quality Commission

Oak Health Uk Ltd

Oakdene Rest Home

Inspection report

165 Minster Road
Minster On Sea
Sheerness
Isle of Sheppy
Kent
ME12 3LH
Tel: 01795 874985
Website:

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Ratings

Overall rating for this service	**Requires improvement**
Is the service safe?	**Inadequate**
Is the service effective?	**Requires improvement**
Is the service caring?	**Requires improvement**
Is the service responsive?	**Requires improvement**
Is the service well-led?	**Requires improvement**

Overall summary

This inspection was carried out on 12 and 14 October 2015. The first day of the inspection was unannounced and we told the provider we would revisit on the 14 October 2015.

Oakdene Rest Home is a home for 26 older people who have a diagnosis of Dementia. The home is over two floors, have both single and double rooms. At the time of the inspection, there were 17 people living at the home.

The home was re-registered on 19 March 2015 to a new provider and registered manager. 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 2014 and associated Regulations about how the service is run.

Summary of findings

People made complimentary comments about the service they received. People told us they felt safe and well looked after. Our own observations showed that the staff were very caring, however the records we looked at did not always match our observation and the positive descriptions people had given us.

Some people may not have received their medicines as prescribed. Suitable arrangements were not all in place for managing medicines, and the recording of medicines did not follow guidance issued by the National Institute for Health and Clinical Excellence.

The planning of care for people included people's physical, emotional, spiritual, mental, social and recreational needs. There was information about people's likes and dislikes. However, six out of the seven family members we spoke with about care planning had not been involved and had not seen their relatives' completed care and support plan. We have made a recommendation about this.

People and staff felt there were usually enough staff deployed in the service. However, the manager could not show us how the staff ratio had been worked out to make sure there was sufficient staff to meet the individual needs of the people. We have made a recommendation about this.

Staff felt well supported by the provider and the management team. The staff team in the home had remained stable for several years and currently there were no new staff. The staff training records showed that not all staff had received necessary training to make sure they have the skills and knowledge required to care for all people's specific needs. Refresher training had also not been provided in a timely way. However, the provider had recognised this and had organised training for the staff, and further courses had been booked.

Staff supervision had not been arranged on a regular basis. However, the registered manager had identified this and supervision was now being diarised every six to eight weeks. Staff told us that they had opportunities to talk to the manager and the provider, if they had any issues or concerns. The registered manager told us that each member of staff was to have an annual appraisal to assess their performance and any further training needs.

People were complimentary about the food and were provided with enough to eat and drink. Choices of menu were offered each day. Some improvement was needed at mealtimes to make sure people ate in a pleasant and homely environment; the current dining room was not large enough for everyone to use. We have made a recommendation about this.

There was a system for managing complaints about the service. People and their families were listened to and knew who to talk to if they were unhappy about any aspect of the service. The complaints policy was on the notice board however it was out of date and did not have current information about external services people could complain to. We also found that complaints had been listened to and actioned however they had not been recorded. We have made a recommendation about this.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. Some people were assessed as lacking capacity to make decisions for themselves at this service. Staff were supporting people following decisions they had made which were in their best interest. Not all staff had received training in the Mental Capacity Act 2015 or DoLS to enable them to do this effectively. We have made a recommendation about this.

Staff were kind and caring in their approach and had a good rapport with people. The atmosphere in the home was calm and relaxed and there were lots of smiles and laughter.

Safe recruitment procedures were followed to make sure staff were suitable to work with the people at the home. People were safeguarded from abuse.

People were supported to maintain their relationships with people who mattered to them. Visitors were welcomed at the service at any reasonable time and were complimentary about the care their relatives received. People were consulted through resident's meetings and their views taken into account in the way the service was run.

During this inspection, we found a breach of regulation relating to fundamental standards of care. You can see what action we told the provider to take at the back of the full version of this 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.

People had not received their medicines as prescribed.

Staff had a good understanding of safeguarding people from abuse

Safe recruitment procedures were followed to make sure staff were suitable.

Is the service effective?

Requires improvement

The service was not consistently effective.

People were complimentary about the food and received enough to eat and drink. However, people's independence and preferences were not promoted in the way meals were served.

Not all staff had received training in the Mental Capacity Act 2015 or DoLS to enable them to support people effectively to make decisions that were not in their best interest.

Not all staff had received the essential training and updates required.

Staff were supervised and annual appraisals were being arranged. They were supported to carry out their roles.

People were supported effectively with their health care needs.

Is the service caring?

Requires improvement

The service was not consistently caring

People or their representatives were not fully involved in planning their care.

Care and support plans were inconsistent.

People's privacy and dignity was protected

Staff were kind and caring in their approach or supported people in a calm and relaxed manner.

Is the service responsive?

Requires improvement

The service was not consistently responsive.

Complaints were not managed effectively to make sure they were responded to appropriately.

People's care was being planned in a personalised way; however this process of change has not been completed.

Most people were provided with a choice of meaningful activities supported to maintain their relationships with people who mattered to them.

Summary of findings

Is the service well-led?

The service was not consistently responsive.

Complaints were not managed effectively to make sure they were responded to appropriately.

People's care was being planned in a personalised way; however this process of change has not been completed.

Most people were provided with a choice of meaningful activities supported to maintain their relationships with people who mattered to them.

Requires improvement

Oakdene Rest Home

Detailed findings

Background to this inspection

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

This inspection took place on 12 and 14 October 2015. The first day of the inspection was unannounced and we told the provider we would revisit on the 14 October 2015.

The inspection team included two inspectors on the first day, with an inspector and expert by experience on the second day. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. In this case they had specific experience with older people with dementia.

We gathered and reviewed information about the service before the inspection. We also looked at information from the local authority and our last report.

During our inspection, we observed care in communal areas; we used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We examined records including staff rotas; four staff files, management records and care records for six people. We looked around the premises and spoke with 16 people, 10 relatives, five care staff, the cook, the registered manager, the deputy manager, and the provider.

This is the first inspection of this home since the new provider took over in March 2015.

Inadequate

Is the service safe?

Our findings

We asked people and their families whether they felt safe. One person said cheerfully, "yep!" and another said clearly, "as safe as I can be, yes." They added, "there've been one or two rumpuses, but that's the men". A third person answered, "I do feel safe. It is all very nice." All of the relatives spoken with felt that their loved ones were safe at the home. One said, "I think he is safe here. He hasn't got out yet". Another said, "she is safe here, and that is the main thing, really."

Medicines were administered to all people living in the home by staff. Assessments showed that currently no one was able to safely administer their own medicine. The registered manager and the staff confirmed that they were only allowed to give out medicines when they had received training and had shown they were competent to do so. We saw a sheet which showed staffs initials, which meant it was possible to recognise which staff member gave or did not give medicine if there were any problems.

Medicines were stored securely in a locked trolley attached to the wall in a lounge when not in use. This was discussed with the registered manager as this was not ideal. Medicines that needed to be kept cool were stored appropriately in a locked refrigerator. There was a chart to record the temperature for the refrigerator daily and this had been completed daily. We saw the storage for controlled medication and where stock medicines were kept. These were kept securely and controlled medication had been administered appropriately with the necessary checks.

The majority of people's medicines had been supplied in a MDS, (Medication dosage system) which had been supplied by a pharmacist. These were filled monthly by the pharmacist. Each person had all the medicine that could be dispensed in this way ready for staff to administer each dose at the right time on the correct day. The pharmacy also supplied MAR (Medication Administration Record) sheets, for staff to complete, recording the medicines as they are taken and giving the reason if they were not. The MAR sheets had been completed correctly with people's personal details, any known allergy and the name of people's GP. The pharmacist had recorded all the details about the medicines on the sheet; this included the dose and the times they should be administered.

Not all medicines could be dispensed in an MDS. For example, some medicines needed to stay in their individual packaging until they are to be taken by the person who was prescribed them. These were recorded on the MAR sheet either by the pharmacy or the staff. We did an audit of the medication that was not in the MDS. Boxes of medicines were chosen at random from the trolley, and the staff member using the MAR sheet told us how many tablets were left in the packaging. Out of the 10 medicines we checked, four did not have the correct medicines left in the person's box. For example, for one medicine recorded on the MAR sheet showed 28 tablets had been received into the home, with 22 tablets signed as being taken. However, we found there were eight tablets left instead of six. This showed that on two occasions, a staff member had signed to say the person had taken their medicine when they had not.

We also looked at a medicine called Warfarin; this had to be given in very controlled doses. People on this medication have regular blood tests and the hospital then contacted the home to confirm the dose to be given until the next blood test. We saw the records indicating the amount of medicine the person needed following each blood test. We checked the amounts of warfarin tablets in there different strengths that had come in and the amount that was left in each box. The home also had stock locked away in the medication room. However, we were not able to reconcile the numbers of these medicines with the stock in the trolley, and/or with what was in stock cupboard. We also found that there was an opened box of 3mg warfarin tablets in the medication trolley that should not have been in use at this time. We therefore were not confident that people were receiving their medicines as prescribed.

Some people were prescribed medicines to be given PRN "As required". For some people, there were no PRN protocol's giving clear instructions about the reason for administration of this medication, the frequency, maximum dose and duration between doses. The amount given was not always recorded. Where medicines were to be given as PRN for pain relief, there was no pain assessment tool in use in the home. Records showed that some people had regular PRN pain relief, others very infrequently. The staff member told us that people were offered the opportunity to have pain relief medicines during every medicine round if prescribed.

Inadequate

Is the service safe?

The examples above showed the provider was not managing people's medicines safely. This was a breach of Regulation 12 (1) (2) (f) & (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Areas of the home had not all been cleaned as they should. For example there was dust on surfaces in some people's bedrooms. One person was employed to undertake the cleaning of the home on week days only. The weekends care staff were expected to do the cleaning, whilst caring for the people. This was discussed with the provider and an advert was put in the local paper the next day for weekend domestic staff. There was a cleaning schedule but this was not detailed enough to ensure all areas of the home were regularly cleaned. It did not specify how often areas should be cleaned and what with. Relatives spoken with told us about the cleanliness of the home. One said, "they seem to clean it every day. They seem pretty good here with the cleaning." Another commented "it normally looks presentable, and there is not often an odour now". A resident, too, said, "the girl was in today, cleaning it all."

We spoke to staff about infection control. Out of the five staff we spoke with about this, only one was sure that the deputy manager was the infection control lead. None of the staff spoken with knew where the spillage kit was kept in the home to use when bodily fluids needed to be cleaned up. We established that the home did not have one. Most staff had a good understanding of the different coloured cloths and the chemicals used on different surfaces. All staff spoken with were aware of the COSHH file (Chemicals or Substances Hazardous to Heath). Staff knew where it was located and knew that if there was an incident with a chemical the file contains the first aid treatment to be given. The training record showed that 11 out of 26 staff had not received training on infection control which meant that staff may not have the knowledge necessary to prevent cross infection. The staff meeting minutes showed that infection control issues were not part of the meeting agenda as would have been good practice.

The examples above showed the provider was not managing infection control measures to ensure safe care and treatment. This was a breach of Regulation 15 (1) (a) (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's care and support plans were not all complete. The manager told us that they were in the process of changing people's files to make them more person centred. However, we found that we were not always able to find the risk assessment that we would expect to find to protect people from harm. With relevant information, and in some cases important information was not being found on file. For example, we were aware that the home had people who were diabetic. We did not find a risk assessment on file, or the strategy to instruct staff if they found the person was showing signs of having too much or not enough sugar in their blood. We also found that no staff at the home had received awareness training regarding Diabetes. Risks assessments seen on files were generally for the mobility and falls only and not all assessments showing significant risk had a recorded risk strategy to minimise people's risk of harm.

The examples above showed the provider was not adequately assessing risk to health and safety or well fare of service users receiving care. This was a breach of Regulation 12(2)(a) (b),of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The staff rota showed how staff were deployed throughout the day. People told us that staff came if they called for assistance. We observed that staff were available in shared areas and checked on people in their rooms throughout the day. However, we did see times when there were no staff available in the main lounge/conservatory area for some time. This is where the majority of people tended to sit during the day. This was of concern as we had witnessed a lady, for example, trying to get up unaided, who normally was assisted to walk by a member of staff.

There did appear to be sufficient staff on duty, it was not usually difficult to find someone. There was, however, a period in the afternoon when at least nine lady residents who were mostly awake, and unsupervised in the lounge. Staff confirmed that breaks were staggered to make sure there were enough staff remaining on duty to meet people's needs. Staff told us they would like more time to spend with people individually, especially when there were no activities at weekends and care staff were expected to also undertake cleaning. The registered manager did not have a dependency level assessment tool to calculate the number of staff needed to meet people's care and support needs in the home. They explained that there were now fewer people living in the home but the number of staff on

Is the service safe?

shift had remained the same. However, as people's needs had changed over time the registered manager must ensure there are sufficient staff with the required skills to meet all people's needs.

We recommend that the service seeks advice and guidance from a reputable source, about deploying adequate staffing to meet people's assessed needs.

Most staff had attended safeguarding adults training and the staff we spoke with had a good understanding of what constitutes abuse and how to report it. One member of staff said she would have no problems in reporting abuse, telling us "I could not, not say anything if I thought someone was being abused and would not care if they were the manager or the owner". They told us they would report to senior staff, and were confident that they would take the necessary action to keep people safe. Staff also knew about whistle blowing, where a staff member reports another member of staff for committing some kind of abuse. They knew that the service would protect them from any reprisals for doing this. They also knew they could report the manager or the provider if necessary to social services safeguarding about any concerns for people's safety.

The premises had been not been fully adapted to meet the needs of people living with dementia. However although we found that doors were all the same colour, and toilets and bathrooms were not always clearly identified using colour, people were aware of where they were. There were patterned wallpapers in communal areas which can also be difficult for people living with dementia. People with dementia can sometime see things within the patterns that may disturb them. The provider was changing these as they redecorated. They were doing this in association with recognised guidance on the use of colour to increase people's independence with dementia. We saw on-going maintenance of the premises was being undertaken by the maintenance person and this included redecoration. There was a record of the day to day maintenance and weekly checks that needed attention. These included replacing light bulbs, checking call and fire alarm systems are working correctly.

We saw that the registered manager had an environmental and fire risk assessment. Staff spoken with were aware of the checks now being made regularly regarding the fire alarm system. Staff said that they had undertaken training and that fire drills happened several time a year. Fire safety equipment and emergency lighting was in place and was now being checked regularly by the homes staff. The equipment was also serviced and check by qualified engineers.

Accidents and incidents were being recorded both in the daily records and appropriate forms. These had been followed up and where appropriate risk assessments had been developed or existing ones had been reviewed. The staff spoke to were aware of the risk assessment in place for individuals in the home. For example, staff were aware of the people who were prone to falls. In some cases staff just needed to offer a person their frame to walk with. Others had alert mats in the bedrooms so staff were aware when they were up and needing assistants so they did not fall.

The new staff recruitment policy and procedure was in place and if followed would make sure that the staff recruitment would be robust. The home experienced a very low turnover of staff, therefore there had been no recruitment required by the new provider. Staff records showed that all staff had previously completed application forms; proof of identity and references were required and checks were carried out including criminal record checks. Staff all confirmed the necessary checks had taken place with the previous provider before they started work at the home.

Personal emergency evacuation plans PEEPs, were available for the people who lived at the home however, these did not contain sufficient detail. This was discussed with the provider and registered manager. These plans are needed to ensure people are evacuated safely in the event of an emergency.

We recommend that the service seeks advice and guidance from a reputable source about the information that needs to be included.

Requires improvement

Is the service effective?

Our findings

People who could respond felt that their health needs were well met at the home. One person told us, "If you are not well they get the doctor and they look after you". The relatives spoken with said that they were happy with the way in which the staff looked after the healthcare needs of their loved ones. A relative told us about her mother, "She had the paramedics in last week, because she had a fall and she was all checked. It was brilliant, they are so thorough." She added that her mother had said, "I was picking up the comb then I was on the floor, but I called out and they found me!" The family felt that the staff had done everything that could be done. They also said that when she first came in, she was very ill. She is so much better now, and that is thanks to them!' Another family said 'they contact us (if she is unwell) and get the doctor straight away".

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. The registered manager was following the process for making DoLS applications, in light of the Supreme Court Judgement which widened and clarified the definition of a deprivation of liberty. Any application or consideration of DoLS starts with the assessment of their ability to make decisions. It is not until they are considered not to be able to make the decision that a DoLS is considered. In this case, where all the people are unable to go out without staff or family support a DoLS referral is required. The registered manager was submitting these a few at a time each month. The registered manager told us as the local authority had asked them to do these this way.

Staff were not all aware of their responsibilities under the Mental Capacity Act 2005 (MCA), and the Deprivation of Liberty Safeguards (DoLS.). For example, we found that 14 out of 26 staff had not received training in the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS), although further training had been planned. However staff spoken with had an understanding of how to support people to make decisions and exercise choice and what it means for a person living within the home who may be deprived of their liberty. Some staff were not familiar with the term MCA and DoLS.

We recommend that all staff are trained in the Mental Capacity Act 2005 (MCA) and DoLS ensures MCA guidance is followed.

Records of health and social care professional visits to the home were in some people's individual care and support plan files. The people's care and support plans however were in some cases difficult to follow. The registered manager explained that the way that the care and support was recorded was changing and currently these files were in a transition process and being changed.

The registered manager explained that the staff currently employed had been there at least two years and that no new staff had been recruited since the new provider took over. The registered manager told us that when they do employ new staff they would be asking staff to undertake the new Care Certificate recommended by the Skills for Care Council. Staff told us that they had received induction training when they started at the home which provided them with the knowledge to provide peoples care safely. The registered manager explained that new staff would shadow experienced staff, and not work on their own until they have been assessed as competent to do so.

Some staff had completed vocational qualifications in health and social care. These are work based awards that are achieved through assessment and training. To achieve vocational qualification candidates must prove that they have the competence to carry out their job to the required standard. This helped staff to deliver care effectively to people at the expected standard. The registered manager was currently undertaking a level five in the management of the home, and one staff member told us they had just completed a level three in care.

We looked at the staff training records and checked with the registered manager to ensure that these were up to date. This showed that not all staff had been sent for refresher training in some of the areas considered as necessary training by the provider. For example, safeguarding adults and moving and handling.

We also found that staff had not been trained in the care of people with specific health needs. For example, we found that 17 out of 26 staff had not attended dementia training meaning the skills within the staff team to support people living with dementia were not consistent. Although, we found when talking to staff that there are incidences of behaviours that challenges on a fairly regular basis, staff

Is the service effective?

had not received training on the best way to deal with the behaviour and to protect themselves and others. Therefore staff members were dealing with these situations without skills and knowledge necessary to ensure a safe and effective outcome. A member of staff told us when people got agitated with each they tried try to get between them so they do not hurt each other. Sometimes that meant the staff got abused. These shortfalls in staff training had been recognised by the provider and registered manager. Training documentation showed that since the new provider had taken over staff had started to receive the training needed. We also saw that a number of courses had been booked to take place over the next few months.

Staff were being supported through individual one to one supervision. These were now being diarised by the registered manager to make sure that staff had supervision regularly in the future. Staff were also received an annual appraisal. The provider had arranged the supervision of the registered manager. We saw that they were supporting them to access necessary training and courses to further their skills and knowledge. The deputy manager and senior staff were going to supervise the care staff. The registered manager said that they are in the process of finding supervision training for the senior staff, until then they would be carrying out the supervisions.

Before people received any care or treatment they were asked for their consent. People smiled when staff spoke to them. Staff asked people before assisting them, for example, they asked where they wanted to go, what they wanted to do. Before assisting them with personal care such as taking them to the bathroom, or helping them with their meals staff asked if they wanted this assistance and waited for a response whether verbal or by body language.

Staff also encouraged people to eat and drink and knew peoples preferences and if they were on special diets. One person didn't want to eat lunch as they said they felt ill and they were given encouragement by a staff member. The same staff member came back and sat with the person for a time and spoke gently in a caring manner, explaining why it was important they ate their food so that the person ate most of their meal. People spoken with were positive about the food served from the homes kitchen. We observed drinks being offered throughout the day, and saw staff support people who found it difficult to eat or drink unsupported..

The kitchen staff provided a number of diets, for example diabetic and a high fat and carbohydrate. The diet requiring a high fat and carbohydrate is often prescribed for people who have lost a lot of weight. People with dementia can stop feeling hungry of thirsty and therefore do not eat or drink as much as they once did. Staff were aware of this and encouraged people to eat their meals and take any supplements that may have also have been prescribed.

Care staff weighed people monthly and recorded the weights in their care plans. They informed the registered manager of any significant weight gains or losses, so that they could refer them to the doctor for any treatment required. Staff recorded what and the amount of food that people ate; in this way they monitored people to make sure they were eating a sufficient and well balanced diet. The homes kitchen had been awarded five stars by the Food safety officer. People were therefore receiving a balanced diet that met their individual needs.

Requires improvement

Is the service caring?

Our findings

Some people were unable to tell us about their care and support because they were unable to verbally communicate or articulate their views. We therefore observed staff interactions with people. We saw that generally staff were responsive to people's needs and were observed chatting to people, listening and responding to them.

Our observations showed that people felt comfortable and relaxed in the company of the staff members as they were joining in the activity and conversation. We also observed one person singing along to the radio. One person who had been dozing in their chair was encouraged to join in and quickly became engaged and was seen to enjoy themselves. Relatives confirmed that they were happy with the care their relative was receiving at the home. One of them called the carers "brilliant" and stressed that "they are like a family here". Another commented, "we are very happy. The girls are lovely and it is a very friendly place". A third stressed, "they are lovely, caring staff, they treat all the residence with respect, they are patient, and very encouraging".

Care and support files were inconsistent. The registered manager told us that the files were in the process of being changed. The newer files looked at people in a more holistic way. This meant that the care and support was described more from the person's point of view. We saw that there were risk assessments in place but again the consistency varied. People and their relatives had not been fully involved in planning how they wanted their care to be delivered. Relatives told us that they had not been involved in making the care and support plan and they had not read it. However, they did say that they had been asked to write down about their relatives past life experiences and they had been consulted with about their family member's likes and dislikes. The staff were also now encouraging relatives to bring in photos and write about their relatives past to go in a booklet called 'My life before you knew me'. The manager explained that these once completed can be used for reminiscence and to manage a person if they became anxious or upset.

Relatives told us that they were informed if their relative was unwell of if there were any specific issues, the staff would tell them then what they were doing to look after their relative. People and/or families were included in the reviews of their care when the social services visited their relative. One relative told us "they ask us if we are happy with what the staff are doing for mum, and whether we feel there is anything else they could be doing. We don't really have a problem with the way she is cared for, I think once we said we would like her to be doing more. We have not had one of these meetings for a very long time, it certainly more than a year more like two years ago now". However, people felt they could ask any staff for help if they needed it. People were supported as required but encouraged to be as independent as possible. In this way people were receiving the care that met their needs and preferences.

We recommended that the provider seeks reputable guidance on how to involve the person and their next of kin in the formation of the person centred care plans.

Staff were generally kind, caring and patient in their approach with people and supported people in a calm manner. We observed people smiling and laughing during their interactions with staff. The atmosphere was calm and relaxed and it was evident that staff knew people well and had a good rapport with them. Staff told us they knew the residents well and they were encouraged to read their care and support plans. People's care was also discussed at handover and they then learned about changes in peoples care.

Staff supported people in a patient manner and treated people with respect. People and family members spoken with said staff treated people with respect and they protected their dignity. Staff described how they promoted people's privacy and dignity. They told us how they protected people dignity when they were providing personal care. One staff member told us said, "I close the door when giving personal care and make sure they have picked the clothes they would like to wear, I check they look nice, check their hair and check they are happy", "I knock on the door before entering and I make sure that they consent before I help them."

Staff were discreet in their conversations with one another and with people who were in shared areas of the home. Although that was not easy when the person was hard of hearing. Staff gave people time to answer questions and respected their decisions. They spoke to people clearly and politely, and made sure people had what they needed. We witnessed a person being helped out of the chair by two staff. They spoke to them, encouraging them, once

Requires improvement

Is the service caring?

standing they got their walking frame and one carer stayed with them as they walked to the toilet. Again speaking to them and reassuring them throughout. We saw staff encouraged people to make choices throughout the day. Such as, what they wanted to eat, what time they got up, whether they wanted to stay in their rooms and where they wanted to sit.

People were supported to maintain their relationships with people who mattered to them. There were no restrictions on visitors to the home. People were able to spend time with their visitors in private in their own rooms or in communal areas. Visitors told us they were always made welcome.

Requires improvement

Is the service responsive?

Our findings

People who were able to told us they received care or treatment when they needed it. One person said, "if I call out they always come, I don't have to wait long at all". Families told us that they felt that staff gave the care and treatment their relative needed and that they responded very quickly if their relative suddenly became unwell. One relative said "The staff have always rung me if there is change in my mum or she is unwell, they will have already called the doctor if necessary. Another relative told us, "They know dad so well, they see the signs when he is not well, it's usually a urine infection, so they get the doctor in, I have every confidence in the staff at the home". A third relative said "Staff calls the doctor or ambulance when it's needed, and they then contact us and keep us informed". Staff responded to changes in people's health and care needs to ensure people's health and wellbeing.

The registered manager explained that a pre-admission assessment was carried out before people were invited to live at the home. They said it was important to make sure that they could meet the person's needs before they moved in. People and their relatives or representatives had been involved in these discussions. People's needs were risk assessed by the registered manager or one of the senior team, with care and treatment being planned and recorded in people's individual care plan. The registered manager said the plan was then reviewed during the trial period and necessary changes made to make sure the person received all the care and support that was needed. We did find one initial assessment on file, most of these assessments had now been archived as the people have been at the home for a long time. The home also received a plan from the local authority if they are funding the placement, in the one we saw this cross referenced with the care they described. By having this base line information when people came in to the home, staff can easily recognise changes in a person and respond appropriately.

The staff told us that the care and support plans were reviewed by the staff. However, as the care and support plans were in transition, we had difficulty locating all the information we were looking for. The registered manager said that completing these was now a priority. While the care and support plans were not fully completed peoples care may be compromised. Staff were able to describe the differing levels of support and care provided to people and also when they should be encouraging and enabling people to do things for themselves. Staff told us support was individual for each person. We saw that people could ask any staff for help if they needed it. Staff showed they understood the needs and preferences of the people they cared for.

Families we spoke with or had completed a questionnaire had raised a concern about people not having enough to do. One of the relatives said they had complained about the lack of activities as his dad used to be a very active man, always doing something. He said "they have got a girl here now in charge of the activities, not sure what they are always suitable, I mean colouring in children's colouring books?" The other thing is they never take people out". We asked the registered manager if the activities co-ordinator goes out with people and if they arrange outings and we were told that they never take people out, either in a car or for walks in the local area. Staff confirmed people only go out if their relatives are able to take them. The provider told us they have one activities co-ordinator currently and intended to increase the activities in the home and include trips out. The activity co-ordinator was on holiday so care staff tried to fit in activities when time allowed. One member of staff confirmed she had been asked to carry out activities; however they felt the variety and type of activities on offer were not enough or sometimes suitable for older people. Other staff members also felt that although they had been asked to carry out activities with people, they wouldn't always have the time to do this due to their other caring responsibilities. There were entertainers that visited the home every 4 to 6 weeks. We saw one of these and the people who watched appeared to really enjoy the afternoon. There were two ladies who dressed up in costumes to match the period of the music they were singing. People joined in and they were smiling. When they finished we heard people talking about the entertainment. On another day although staff called the sessions Karaoke it was one of the care staff singing. They had a beautiful voice and the people listening were really enjoying it and sang along with some of the songs. People had limited access to meaningful activities to keep them occupied and stimulated. We were aware that staff were frequently visiting people who remained in their bedrooms through necessity or choice. One staff member said "it is important they don't feel forgotten or isolated".

Requires improvement

Is the service responsive?

We recommend that the provider seeks advice from a reportable source about the type of activities and outings are suitable for elderly people with dementia.

People and their families were given information on how to make a complaint. People and their family were given the opportunity to raise any concerns when visiting the home. Relatives spoken with said they would be confident about raising any concerns. One person's family member said, "There have been times when I have not been happy about something I have complained. They always sort thing out straight away". The registered manager said that any concerns or complaints were regarded as an opportunity to learn and improve the service, and would always be taken seriously and followed up. Families told us they knew how to raise any concerns and were confident that the provider and registered manager would deal with them appropriately within a set timescale. In the complaints file we saw that no complaints had been recorded since the home changed provider. The registered manager said that this was because any concerns had been dealt with straight away. They had not received any formal complaints. There was a complaints policy and procedure in place, giving time scales for action and where and what should be recorded. The file also contained the complaints log which if completed would highlight any patterns in complaints so improvements could be made to the service provided.

We recommend that the provider's policy and procedure is shared with all staff so that in future all concerns and complaints are recorded.

One relative told us that she had received a satisfaction survey, "but I haven't filled it in yet. I will though". People were asked for their views about the home in a variety of ways. These included formal and informal meetings; events where family and friends were invited; and annual surveys. People and their families told us that there was good communication with the registered manager and provider. This meant that people were being asked about their experiences of the service to improve or monitor quality. The provider explained that the meetings were important as they were new and going through a period of change regarding the management of the home. They found people's families had been concerned, they were worried the home might change but not for the better. The provider explained that they had made themselves available to talk to families when they had concerns.

We saw three surveys that had been returned so far from families. The questions included catering and food, personal care, premises and management. All three families were pleased with the meals at the home one wrote 'the meals are varied and menu board is informative, it's nice to know that it is good wholesome, homemade food and my mum seems to enjoy it'. Under premises we saw that people felt that the home was in need of redecoration, another would like to see foot stools introduced as they know older people like to put their feet up and several of the people have swollen ankles. Under management all were satisfied with the management and there were three different comments made, one said 'I have always found the management ready and willing to talk to me about any concerns I have', another said that they are waiting to see how things change and hopefully improve under the new management. The other person highlighted an issue in the home about the key fobs given out by the previous owns so families could let themselves into the home.

The provider was aware of the comments made and for example the issue regarding families having access to the home at any time without staffs knowledge. The new owner had spoken to families about this as this is not appropriate or safe. However families have been reticent about giving the fobs back. He said this was done by the previous owner as families had said it had taken staff a long time to open the door when they were busy. The provider was in the process of looking for a new system that would allow staff to let families in from different parts of the building and enable the staff to know who was in the building. The provider said apart from not being safe, this is people's home and their privacy and dignity needs to be protected.

Requires improvement

Is the service well-led?

Our findings

The home had a registered manager who had been in post since March 2015. People, families and staff spoken with said that there have been noticeable changes in that time. People and relatives spoke highly of the staff. We heard positive comments about how the home was run by the registered manager. One relative said, "registered manager always has time for me, always. If I have concerns, or just need to talk, she will always stop whatever she is doing for me." Newer relatives were happy that they had 'met both the registered manager and the owner. Another said that the home, under this manager "runs smoothly". He had noted "a change in the atmosphere" with the new provider, and was pleased that, "it is the same carers, they haven't left".

The registered manager, provider, and the staff were well known by people in the service. We observed them being greeted with smiles and they knew the names of people or their relatives when they spoke to them. Relatives told us, staff always speak when they see you, one relative said, "we are always welcomed by the manager, whoever, all the staff are easy to talk to".

The aim of the home was to provide care built on individuality, independence and personal dignity, doing this by providing sensitive care, allowing people to live a normal a life as possible. We found that staff did have an understanding of the aim of the service. When asked, one staff member told us "it was to care for people how they wanted to be cared for and help them remain as independent as possible". Another said "We care for residents as individuals, understanding their specific needs and maintain their dignity. All staff who were asked what the service did well also said that they provided good individualised care and that all staff know the residents well and what care they each needed.

There were systems in place to review the quality of the service. The systems were being changed to those of the new provider, and they were gradually being embedded. The audits would be all encompassing so that all aspects of quality would be reviewed on a regular basis. Monthly and weekly audits seen carried out covered areas such as health and safety, fire regulations and accident and incidents. Medicine audits had been undertaken weekly and monthly, however they had failed to pick up the errors we identified. For example that medicines remaining in stock at the start of the next time period/ MAR sheet had not been documented as carried forward.

The provider had recently made arrangements for an operations manager to also audit the systems and the premises to identify any shortfalls or areas for improvement each month. Their findings would be discussed with the registered manager and where necessary action plans would be put in place to make sure safety and wellbeing would be preserved. For example, we found that no complaints had been recorded when complaints had been received because they had been dealt with straight away. The registered manager was now completing the complaints log and this will be discussed each month to see if there were any patterns to the complaints so that more robust changes can be made to improve the service. These examples showed that there had been gaps in the audits carried out in the home.

Staff were aware that the registered manager was available for staff to speak to at any time. Staff were positive about this and felt able to discuss areas of concern and make suggestions. Staff understood the management structure of the home, their roles and responsibilities in providing care for people and who they were accountable to.

Communication within the service was facilitated through shift handovers, regular meetings and staff supervision. Minutes of staff meetings showed that staff were able to voice opinions and these were listened to and acted upon. Staff told us, for example, there was good communication between staff and the registered manager. The registered manager always listened to their concerns and ideas. For example, the way the domestic rota was arranged, there was just one member of staff cleaning the building during the week and none at weekends. The provider has now put an advert out for domestic staff for the weekend and to cover annual leave.

There was a range of policies and procedures governing how the service needed to be run. These were being introduced by the new provider; they were being reviewed to make sure they were worded suitably for the home and the kind of people living there. Policies and procedures were therefore being changed gradually. The staff had easy access to these, they were being encouraged to look at them, and refer to them when necessary.

Requires improvement

Is the service well-led?

The registered manager was aware of when notifications had to be sent to the Commission. These notifications told us about any important events that had happened in the home. For example the manager has to inform us when a DoLS referral has been accepted by the local authority. We used this information to monitor the service and to check how any events had been handled. This demonstrated the Registered Manager understood their legal obligations.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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
	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Risks to people's safety were not being assessed or mitigated effectively. Regulation 12 (2)(a) & (b) People's medicines were not managed safely Regulation 12 (2)(f) & (g)

Regulated activity	Regulation
	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care Regulation 9 (1) The provider was not doing everything reasonably practicable to make sure people received person-centred care and treatment that reflected their personal preferences.

Regulated activity	Regulation
	Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010 Safety and suitability of premises Regulation 15 (1) (a) (2) The provider must make sure the home is clean and maintain standards of hygiene