Unity Homes Limited

Oakbank Care Home

Inspection report

Oakbank
off Rochdale Road
Manchester
Greater Manchester
M9 5YA

Tel: 01612058848

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11 April 2016
12 April 2016
15 April 2016

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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

We carried out this unannounced 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 and to provide a rating for the service under the Care Act 2014.

We inspected the service on the 11, 12 and 15 April 2016. Oakbank Care Home is owned by Unity Homes Limited and is in the Harpurhey area of Manchester. The home is registered to provide accommodation for up to 55 people including those who need nursing care. The home has two floors and has gardens at the rear of the home. Car parking is at the front of the home.

At the time of the inspection there had been no Registered Manager in post who was registered with the Care Quality Commission (CQC) since 2012. This was due to person who was in the process of being registered as manager, going off on long term sick. However, the current manager was in the process of registering with CQC. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

We did not speak with the manager until the third day as they were not present due to planned leave.

Care records contained person centred information to guide staff on the care people needed and had agreed to. However, these were not always reviewed and updated when changes occurred. We saw a variety of health assessments were in place to ensure referrals to other health professionals were made as appropriate.

Staff we spoke with were knowledgeable of the needs and preferences of the people they cared for. We spoke with people who lived at the home and their relatives. We were told they were happy with the service the home provided. Comments we received included; "Oh I'm well looked after here I can assure you" and "Staff are great."

Our observations during the inspection showed us that people were not always supported by sufficient numbers of staff. Staff recruitment was not safe as the service had failed to carry out all the required checks on staff to ensure they are safe to work with vulnerable adults. Staff we spoke with confirmed they attended training and development activities to maintain their skills and that further training was planned. We also viewed documentation that showed us there were recruitment processes in place and staff confirmed these had been carried out when they had been employed.

During the inspection we saw staff were attentive and patient when supporting people and people were encouraged to eat and drink to meet their needs. However, staff were task focused at times due to staffing

levels and the needs of people. We observed people being offered a limited choice and if people required assistance to eat their meal, this was done in a dignified manner.

We saw that there were procedures in place to instruct staff in the action to take if they were concerned that someone was at risk of harm and abuse and the staff we spoke with were knowledgeable of these procedures.

We discussed the quality assurance systems in place with operations director and the manager of the home. We were told audits of accidents, incidents and falls were carried out and these were investigated by the manager to ensure risks were identified and improvements made.

We identified breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we have taken at the back of the full version of the report.

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.

Staff recruitment was not robust; there were insufficient staff on duty to meet the needs of people living at Oakbank.

Risk assessments had been completed, however where risks had been identified, action had not always been taken to mitigate the risks. Risk assessments were not regularly reviewed and updated.

Infection control practices were not always safe.

Medicines were administered appropriately but staff had not always documented the reason why medicines had not been taken.

Is the service effective?

Requires Improvement

The service was not always effective.

People complained and we saw there was not sufficient food to meet people's needs.

Staff general understood and followed legislation in relation to the MCA and DoLS.

Staff had received appropriate training to be able to carry out their role.

Is the service caring?

Requires Improvement

The service was not always caring.

People were not always treated with dignity and respect, bedroom doors were left open without people's consent overnight.

Care and support could be task orientated at times, due to staffing levels.

Staff were kind and caring to people living at Oakbank.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care plans were person centred but had not been reviewed regularly so did not reflect the person's current level of needs.

Activities were planned and people who could attend enjoyed a variety of social interactions.

The service had a complaints procedure in place which showed complaints were investigated and responded to appropriately.

Is the service well-led?

Requires Improvement

The service was not well-led.

Audits were being completed however where issues were identified, no action had been taken.

There had not been a registered manager in position for since January 2013. The present manager had not yet registered.

Staff worked well as a team, however staff reported that moral was low as they didn't always feel listened to.

Oakbank Care Home

Detailed findings

Background to this inspection

Start this section with the following sentence:

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

This inspection took place across three dates 11, 12 and 15 April 2016 and was unannounced on the first day. On all three days of the inspection, two adult social care inspectors were present.

Prior to this inspection we looked at all the information we held about this service. We reviewed notifications of incidents that the provider had sent us since our last inspection and we asked local commissioners for their views about the service provided. We had asked the provider to complete a Provider Information Record (PIR), which told us key information about the service, what the service does well and improvements they plan to make. We used this to inform our planning. We also requested feedback from social work professionals from the adult safeguarding team at the local authority. We also received information from families and relatives of people who used the service.

We engaged with most of the people who lived at the service; however feedback was variable due to some people living with dementia being unable to communicate.

We spoke with five people, five relatives and/or visitors, four care staff, kitchen staff, the activities coordinator, the maintenance person, the manager, the operations director, the nurse in charge and a care consultant appointed by the provider.

We looked at six people's care records, staff duty rosters, four recruitment files, training records, management audits, medication administration records (MARS) and quality assurance documents.

Over the lunchtime period on day one of the inspection, we conducted a 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.

Requires Improvement

Is the service safe?

Our findings

We asked people living at Oakbank if they felt safe. Some comments included: "Oh, yeah", "Oh yeah, never more." and "I feel safe, it's alright". Another person told us "I feel safe". Relatives we spoke to responded with, "Definitely safe" when asked if they felt their relative was safe living at Oakbank. Another relative said, "Safe? Yeah". Other comments from relatives were, "Yeah, I really do (feel they are safe)" and "I feel safe leaving [name of person] here".

Even though people told us they felt safe at Oakbank they felt there weren't enough staff to meet people's needs. One person told us, "Night times are terrible, they are so short staffed." Another person said, "There's not always enough of them [carers]". We asked relatives whether they thought there were enough staff to meet the needs of their family member. One relative told us, "I'm concerned about the night". Staff members told us, "Today we are fully staffed, some days we are short. Staff ring at the last minute, makes it difficult to cover". Another staff member said, "No, not enough staff one more on-board on a daily basis, morning, afternoon and nights (would help). We struggle with four on during the day time (on the ground floor). They class the nurse as another one, but we are short with her doing her own job. Twenty people need double ups [support from two care staff] (on the ground floor)." A third staff member said, "If someone phones in sick, then no [not enough staff]". All other staff we spoke with agreed that there weren't enough staff and nights in particular

We were told the service used a dependency tool to ensure the number of staff on duty was sufficient to meet the needs of those living at Oakbank. We checked staff rotas and found that on duty there should be one senior carer and four carers on the first floor (residential) and one nurse and four carers on the ground floor during the day. On the day of inspection we saw the staffing levels matched the rota. Staff commented that this wasn't usually the case. At night there should be a nurse and two carers on the ground floor and a senior carer and two carer staff on the first floor. We arrived for our first day of inspection, when night staff were still on duty. We found that overnight there was a nurse and a care staff member on the ground floor and a senior care staff member and a care staff member on the first floor. There were people who required nursing care, being cared for on the first floor so at times during the night there was one carer being left on the ground floor. We noticed that everyone's bedroom door had been left open; we were told this was for safety due to the low number of staff on duty. We were told the reason they were low on numbers was because someone had rung in late to say they were unable to come into work and despite trying to get cover from an agency, it was too late to find anyone to cover that shift. We checked the staff rota and found there were issues with staffing levels when people called in sick. A staff member told us they had been told by the manager that if they were concerned about staffing they should go to the nurse or to her and "my door's always open". Not having enough staff on duty was a risk those people living at Oakbank as there were not enough staff on duty to meet their needs.

The failure to have sufficient staff on duty was a breach of Regulation 18 of the Health and Social Care Act 2008(Regulated Activities) Regulations 2014.

We looked at whether the recruitment of staff was safe. We found the recruitment process was not robust as

not everyone had a full employment history within the recruitment file, not everyone had two references and we found the there was no photographic ID for one person. Checks had been completed with Disclosure and Baring Service (DBS) prior to staff starting working in the service. The DBS helps employers make safer recruitment decisions and prevent unsuitable people from working with vulnerable groups. Not having all the required documents meant the recruitment process was not safe.

The failure to ensure staff were suitable to work with vulnerable people was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

Staff members we spoke with were able to explain the basic principles of protecting people from abuse, and knew how and to whom they should report any concerns. Staff told us they would report it to the manager and if they weren't in, then the number was on the wall for the safeguarding team.

We looked at the safety and suitability of the premises. We had concerns regarding trip hazards. The floor in the main corridor of the first floor was a significant hazard along its full length due to the floor being uneven. The décor of the premises was 'tired' We detected a slight odour on entering the home. We raised this with the operational director who took action and immediately put up signs to warn people and visitors about the uneven floor.

We checked people's care files and found risk assessments in place which were personal to the person's needs. These were not always being reviewed and updated as required. We saw that where an external audit of the care files had identified gaps in the risk assessments, actions had not yet been taken since they had been identified in February this year. This meant that people's risks may not be fully mitigated to ensure they received safe care.

We checked the services accident and incidents records were appropriately kept in line with data protection guidelines. We found they were, however there was no analysis or lessons learnt recorded and no clear actions from these. Meaning the service was not demonstrating how it would reduce the risk of these incidents occurring in future.

We saw evidence of personal emergency evacuation plans (PEEPS) were detailed and provided information should the person require evacuation due to an emergency such as a fire. External risk assessments such as health and safety, legionella and fire safety and been completed. We saw the manager had completed the fire risk assessment; however this needed to have been completed by someone who had received the appropriate training do this. We raised this with the provider who agreed to take action.

We checked to see if medicines were stored, administered and disposed of correctly. When we checked the medication administration records (MAR) we found that when medicines had not been administered, there was no signature or rationale for this. We spoke to the nurse in charge who said this would be addressed. We checked to see if the number of tablets matched the amount recorded and found they did. We observed medicines being administered to people living at Oakbank and saw that these were done safely and as prescribed. We saw that a person required their medicine prior to food; therefore the service ensured that this was administered by night staff. This showed the service had identified this as a risk and taken action to prevent any delay in this person receiving their medicines.

We were told that an infection control policy was in place; however we noticed that staff did not comply with safe procedures for the prevention and spread of infection and disease. We observed some staff used personal protective equipment (PPE) whilst providing personal care and then fail to remove their PPE before leaving the area where intimate care was provided. We spoke to staff about the use of PPE and we were told

that they often run out at the weekends as the supplies are kept in a cupboard which only the domestics and manager can access. We discussed this with the manager, who assured us that this was not the case, and all of the nurses on duty would know the code to access the cupboard. This increased the risk of cross contamination of infectious disease.

We viewed the kitchen and found food wasn't always labelled and raw meat products were being stored on the top shelf of the fridge. This could result in the contamination of other products. We saw there was evidence of stock rotation and use by dates put on food. We found some food products were being stored in containers on the floor in the kitchen and not on the shelving units.

Requires Improvement

Is the service effective?

Our findings

During the inspection we were only able to speak with one relative so we contacted other relatives by phone after we had completed our visit to Oakbank Care Home. We did this to ascertain their views of the service provided. One relative told us their family member was "Well cared for. Quite happy with the home at the moment". A second family member we spoke with told us "Couldn't compliment them any more than 100%".

People we spoke with told us "The food is terrible; I understand there are lots of people here, but its quality [pulled a face to indicate the quality was poor]. We have no choice. Today, they have no coffee, I only drink coffee. Today I had a sandwich as I didn't like the main. Staff get grief for it but it isn't there fault". Another person told us, "I just have a sandwich, the foods not that nice". Staff members we spoke with also commented on the quality of the food, their comments included, "There's not enough food to go around" and "No, the residents are not involved in choosing the food". Another staff member said, "In the residents meetings, they complain a lot about the food. Some of the meals are good". Other comments received were, "Food could be improved, not the fault of the kitchen staff, it's the amount. People aren't involved in the menu planning, some residents complain about the menu". Relatives told us, "[name of person] really likes the food" whereas another relative said, "[name of person] is always asking for more food".

We were told people had recently complained about no longer having the choice of a full cooked breakfast. This was fed back to the provider and they now have the option of a 'brunch' twice a week. We were told people were not happy with this but no other options had been offered. We discussed improvements that were currently being made with the manager and were told a hospitality consultant was in place to review the current catering provision. We spoke with the hospitality consultant who confirmed they were reviewing the menus at Oakbank Care Home.

We observed people eating their midday meal and saw they were offered a choice of whether to eat in the communal areas or in their own room. Some people chose to eat their meal in their room and we observed the tray was well presented with napkins, condiments and a drink. People were asked if they were happy with the meal before staff left. People who chose to eat in the communal areas were not asked where they wanted to sit although the tables were clean with napkins, drinks and condiments available. We observed people being encouraged to eat and staff observed people to ensure they ate. If a meal was declined staff offered sandwiches as an alternative. Meals were not attractively presented; we saw people were given a sausage roll and a scoop of baked beans or a sandwich. We did not see people being given a choice of filling in the sandwich. The atmosphere during the meal was not a sociable one; people were not chatting and not did not look relaxed. We observed the lunchtime meal was a neutral experience.

Staff knew people who had additional nutritional needs such as requiring a puree diet or a fortified diet. Staff told us those who were on food and fluid charts had the amount they ate recorded immediately after the meal. We observed this was the case. Staff also explained how they met people's cultural needs, for example a person required a halal diet so all meat purchased by the service was halal and they ensured the person wasn't served pork. However when we looked the persons food and fluid chart it was recorded they

had been served 'pork'. This was raised with the manager who agreed to look in to this and believed it had been recorded in error.

Our findings show the service did not give people choice with regards to menu planning. People's views were not sought and there did not appear to be enough food for to support the nutritional requirements of those living at Oakbank. We found people's weights were not always updated, so it was unclear if people were losing weight because of this.

The failure to ensure sufficient food was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

The Care Quality Commission (CQC) is required by law to monitor the operation of the Mental Capacity Act 2005 (MCA) Deprivation of Liberty Safeguards (DoLS), and to report on what we find. At the time of this inspection we were informed there was one DoLS authorisation in place. There had been an increase in DOLS submissions in February due to a care consultant who was employed by the service advising them to do so. The manager explained the circumstances that would indicate a DoLS application should be made and the processes for this to be carried out. We saw historical documentation that showed us if an application was made, the correct processes were followed to ensure people who did not have the capacity to make significant decisions about their care and welfare had their rights upheld.

We observed staff seeking consent prior to completing any care and support with people. Staff we spoke with had an understanding about the MCA and DoLS and how it applied to their role. One staff member told us, "Best interest of each person's needs, each individual is different in here. I make a decision for them if it's in their best interest. We are not allowed to lock the door. One resident puts his wheelchair strap on himself, it's his choice".

The manager told us they maintained staff files for staff who worked at Oakbank Care Home. We viewed staff training files and saw staff had completed a range of training courses. The staff we spoke with told us new staff received an induction prior to starting to work unsupervised with people and in addition training was arranged to enable them to maintain and update their skills. They told us and we saw documentation that showed staff had attended training in safeguarding adults, moving and handling and infection control. Staff told us and we saw evidence that further training in safeguarding, the Mental Capacity Act and First Aid was arranged.

All the staff we spoke with told us they felt they received sufficient training and development to enable them to carry out their role. They also told us appraisals were being planned. We discussed this with the manager who told us appraisals were scheduled to take place and staff received supervision every couple of months to identify training needs and evaluate their performance. This showed us the home had processes in place to ensure staff were supported to review their practice and complete training and development activities that met their individual needs.

People were referred to healthcare services when required. Referrals to GP's, opticians, speech and language therapists (SALT) had been made in a timely manner. For example when someone had difficulty

swallowing a referral was made to the SALT team to assess their swallow ability. We saw this had been completed in a timely manner and guidance recorded for staff to follow in relation to supporting this persons change in needs. One staff member said, "I'd call in the dietician if people are losing weight. They normally put people on supplements and monitor their weight."

Requires Improvement

Is the service caring?

Our findings

People told us, "Staff are alright". One person described the staff as "Always happy to help". Relative's comments included, "The staffs mood and attitude is fantastic". "Attitude of staff [to people] is second to none".

We observed people's dignity be compromised at the beginning of the inspection as bedroom doors were propped open. We asked the nurse in charge why so many bedroom doors were fully open given that people were asleep in their bedrooms. We were told that this was the only way in which they could ensure people's safety during the night because of the shortage of staff. We spoke to people during the day whose doors remained open and they told us they "chose for the door to be left open." Staff knew how to maintain people's dignity when supporting them and told us they always ensured people were covered as much as possible with towels when they provided personal care. They also told us they make sure curtains are closed and they knocked before entering a person's bedroom.

We observed staff encouraging people to be independent. We saw one person ask a staff member to put an item of clothing on them. The staff member told us this person was able to do it themselves, they just needed encouragement. We saw the staff member approach the person and offered them encouragement to complete the task themselves, which they did. The staff member told us it was about maintaining people's independence and not just taking over.

We conducted an observation known as a SOFI (Short Observational Framework for Inspection) during the lunchtime meal at Oakbank. All staff were seen to be kind and caring in the way they spoke with people. They knew people well and knew who they could laugh and joke with and who they needed to be more formal with. However at times we found the atmosphere within the home to be noisy, and staff appeared busy throughout the day. We found a lot of interactions outside of the meal times to be task orientated, staff did not have the time to sit and 'chat' with people. Meaning some people were at risk of becoming socially isolated.

We observed people being treated with empathy and respect during the inspection. People approached staff, or asked for support freely and without hesitation. Staff were seen to be kind, patient and continually communicated with people and offered advice and support without hesitation. For example we observed staff asking people if they wanted an apron on to protect their clothing, rather than just putting one on them.

We saw the care records were person centred and contained information that was important to the person, for example preferred name, preferred routine and activities. This information enables care to be delivered in accordance with peoples' wishes and preferences. People had end of life care plans in place where appropriate and we saw people had been involved in writing these.

We saw in the reception area, a list of advocacy services and telephone numbers however when we asked if people had their own list, the manager said, "No". We discussed with the manager if people who used the

services knew how to access advocacy services, the manager told us that they only had access to the list in reception, the list was not given to them individually. We looked around the home and did not see any literature that would assist people in making independent decisions or any evidence that advocacy services had been used. This meant people may not be aware of advocacy services which are available to them.

Requires Improvement

Is the service responsive?

Our findings

When people moved to the home, they, and their families where appropriate, were involved in assessing and planning the care and support they needed. People had signed relevant sections of their care plan and the pre-admission form was detailed and provided information to staff about the person's individual needs and preferences. People told us on the whole they were happy with the care provided.

We found that people's care plans were person centred with them containing 'preferred priorities of care' but had not always been reviewed so may not give a true reflection of a person's current needs. The care records we saw were comprehensive and well organised. Each care record contained an assessment that was completed prior to admission, we saw care plans were developed and these contained good information to enable staff to meet peoples' needs. The care plans and risk assessments had been reviewed by the care consultant and any changes needed or identified were recorded in the care records. However we found that staff had not updated the care plans in a timely manner to reflect the issues the care consultant had identified. This was raised with the operational director who agreed that he would speak with the manager to ensure these were done immediately.

Staff knew what person centred care was and knew the people they provided care and support for. Staff knew when to make referrals to other agencies if people's needs changed.

The staff we spoke with told us people who lived at the home were asked if they wanted to be involved in organised activities. We saw people were asked if they wanted to participate in an arm chair exercise activity. The staff we spoke with told us; "Since [name of activities coordinator] has been here, there's lots for them [the people] to do". Another staff member said, "People have activities, weather permitting they can go out in the garden and pot plants". People confirmed they were able to attend activities if they wanted to. We saw the activities coordinator spent time providing one to one support for those who were unable to leave their bedrooms.

The home had a newly decorated residents coffee room which was kept locked. Staff told us that not all of them had the access code and some felt this room should be left open instead of being locked. However we were told by the manager and another member of staff that the reason this room was kept locked was because a person living on the same floor as the coffee room was now no longer able to take food or drink orally and food and drink was kept in this room. This person kept forgetting they couldn't, so to prevent this person from coming to harm, they decided the safest option was to keep the door locked when not in use. We did not see evidence of this being documented or a risk assessment to show this was the reason.

In the reception area of the home we saw blank surveys were in place for people to complete. We viewed a sample of eight completed surveys and saw positive comments had been made. These included "It's the place I feel my Mum is looked after and cared for.", "Overall father is very content here and very happy with what's done for him." We saw evidence that 'Service User Questionnaires' had been completed and we viewed a sample of these and saw comments were positive. Residents meetings were held every other month and we were told that people often raised the 'quantity, quality and choice of food' in this meeting.

We saw these meetings were recorded. We saw minutes from the last relatives and residents meeting and saw a comment had been made regarding a canopy being provided over the patio area to enable people to sit outside if it was raining. We were told by the operational director this had been completed as a result of the feedback and on the day of the inspection we saw this had been done and people were able to sit outside under cover if they wished to do so. This showed us the home responded to suggestions for improvements.

We saw the home had a complaints procedure in place to enable people to have their complaints formally recognised and investigated. We viewed the home's complaints file and saw documentation that showed us the home responded to and investigated complaints appropriately. We saw there was a process in place to enable people to make complaints if they wished to do so.

The relatives we spoke with told us they were involved in planning the care and support their family member received and we saw documentation in the care records we viewed that showed us this took place. This helps ensure that important information is communicated effectively and care planned to meet people's needs and preferences.

Requires Improvement

Is the service well-led?

Our findings

At the time of the inspection there had been no manager in place who was registered with the Care Quality Commission (CQC) since January 2013. This was due to person who was in the process of being registered as manager, going off on long term sick. Prior to our inspection we contacted the operational director who confirmed they were aware of this. They told us the current manager responsible for the day to day running of the home was in the process of submitting their application to become the registered manager to the CQC.

We looked at the quality assurance systems in place and saw various audits were carried out to ensure improvements were identified. Environmental audits were completed and these included water temperatures, electrical checks and equipment checks. Staff we spoke with confirmed audits were carried out and they received feedback of these through staff meetings, supervisions and one to one meetings We saw there were audits in place to check care records contained accurate and up to date information however we saw no action had been taken on the issues identified. We raised this with the provider who said they would be discussing this with the manager to ensure that action would be taken on issues identified.

We spoke with the manager, the operational director and the care consultant employed by the provider to audit the service and develop an action plan who described the changes that were being planned for the home. We saw they had a clear vision of the changes they wanted to implement and the reasons for these. For example the plan was to speak with all staff through supervisions and team meeting to ensure that everyone was on board to work towards the same targets. This had begun with the appointment of the manager.

Some improvements had been made as a result of the introduction of action plans, for example, we saw the record of the provider's safeguarding central monitoring log which recorded the nature of safeguarding alerts, actions taken and outcomes. However, as it was early days we did not see any evidence of how any learning from safeguarding outcomes would be put into daily practice. During the inspection we observed the interactions of staff and saw the home was organised with staff working as a team. We saw staff were knowledgeable of their role and the responsibilities they had to ensure people received care in a manner consistent with their needs. The atmosphere was relaxed and calm and we observed staff carrying out their duties efficiently. Staff were engaging with people in a way that promoted confidence and trust. We saw people who lived at the home engaged spontaneously with staff and initiated and responded to conversations and interactions.

Providers are required to notify CQC of certain incidents which occur, so we can monitor the safety of services and take regulatory action where required. We were receiving notifications of incidents, however the service was no longer analysing the information, looking for trends.

The failure to monitor and assess the quality of the service was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

All the staff members we spoke with were complimentary of the new management team. Some said that morale was low and they weren't always listened to. However, others did feel listened to and told us the manager was approachable. We were told; "There is a clear management structure. I do find the manager is a very good manager. She's caring and approachable. Things get done." We asked relatives their opinion of the management at the home. One relative said, "I know who the manager is, I can speak to her at any time". Another said, "I can't praise them enough [staff and management at Oakbank]. They've done more than enough for [name of person and family member]."

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 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs The failure to ensure sufficient food was a breach of Regulation 14 (1) (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The failure to monitor and assess the quality of the service was a breach of Regulation 17 (1) (2) (a) (b) (c) (d) (f) of the Health and Social Care Act 2008(Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The failure to ensure staff were suitable to work with vulnerable people was a breach of Regulation 19 (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing The failure to have sufficient staff on duty was a breach of Regulation 18 (1) of the Health and Social Care Act 2008(Regulated Activities) Regulations 2014