Mr Raja Singh & Mrs Maninder Kaur Singh

Oakendale Residential Care Home

Inspection report

17 Rose Terrace
Ashton-on-Ribble
Preston
Lancashire
PR2 1EB

Tel: 01772720937

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

The inspection took place on 29 & 30 October 2015 and was unannounced.

This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection was also carried out to follow up on breaches of regulations which we identified at our last inspection in June 2015 and in response to heightened concerns from the Local Authority Safeguarding team.

At our last inspection, in June 2015, we found the provider was in breach of legal requirements relating to staffing, safe care and treatment, consent, meeting nutritional and hydration needs, premises and equipment, person-centred care, good governance, safeguarding service users from abuse and improper treatment and statutory notifications.

During this inspection we found that although the provider had begun to make improvements in some areas, they were not yet meeting legal requirements.

Oakendale Residential Care Home is a small care home which is registered to provide 24 hour care to up to fifteen older people. The home is a converted large domestic property, split over three floors. The home has been fitted with a lift and stair lift to reach the upper levels.

The home had a 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 2008 and associated Regulations about how the service is run.

The provider had not ensured that sufficient numbers of suitably qualified, competent, skilled and experienced persons were deployed at all times. This was in breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Recruitment procedures had not been operated effectively to ensure persons employed at the service were of good character and had the qualifications, competences, skills and experience necessary to carry out their role. This was in breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service had not established, and operated effectively, systems for the proper and safe management of medicines. This was in breach of Regulation 12 (2) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered person had not ensured risks to the health and safety of people were properly assessed and they had not done all that was reasonably practicable to mitigate any such risks. This was in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered person had not maintained an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided and of decisions taken in relation to the care and treatment provided. This was in breach of Regulation 17 (2) (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had not ensured staff had received such appropriate support, training, professional development, supervision and appraisal as was necessary to enable them to carry out the duties they were employed to perform. This was in breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service was not working within the principals of the Mental Capacity Act 2005. Additionally, the service had not sought and recorded people's consent to care and treatment. This was in Breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The nutritional and hydration needs of service users were not being met. This was in breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was very little evidence to show that people or those close to them, where appropriate, had any input into the care planning process. This meant people's views and opinions were not taken into account when their needs were assessed, or when their care was planned and delivered. This was in breach of Regulation 9 (3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were not treated with dignity and respect. This was in Breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service did not demonstrate good management and leadership at all levels. The systems designed to assess, monitor and improve the quality of the service provided were not being operated effectively. This was in breach of Regulation 17 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

The service had not submitted statutory notifications, as required, with regard to significant events. This was in breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

Training records showed and staff confirmed that they had undertaken training in relation to safeguarding people who may be vulnerable by virtue of their circumstances.

We saw some improvements had been made with regard to the premises. The provider had begun a programme of redecoration and refurbishment at the home. A number of rooms were in the process of being redecorated during our inspection. The provider was also in the process of obtaining quotes to modify the ramp access at the rear of the property to make it more accessible for people who used the service.

The home did not have any links with advocacy services, nor was there any information available at the home for people who used the service on how to access such services.

People and their relatives told us there were no restrictions on visiting times.

The provider was looking into different ways of gaining people's feedback in addition to conversing with them during time they spent at the home.

The overall rating for this service is 'Inadequate' and the service is therefore in 'Special measures'.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The 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.

Although the provider had slightly increased staffing levels, we found there were not enough staff deployed at all times to meet people's needs safely.

Robust recruitment procedures had not been operated effectively to ensure that staff employed were suitable to work with people who used the service.

The service did not operate effectively systems and processes to ensure the proper and safe management of medicines.

The service had not properly assessed and done all that was reasonably practicable to mitigate risks to individual's health and safety.

The service had not recorded accidents and incidents for significant periods of time. Other records which were kept in respect of people who used the service were not accurate and up to date.

Is the service effective?

Inadequate

The service was not effective.

People did not receive care from staff who were well trained, with the right skills and knowledge to carry out their roles effectively. Staff were not sufficiently supported by way of regular supervision and appraisal.

The service did not carry out assessments of people's capacity to consent and had not sought consent to care from people who used the service in line with legislation.

Staff knowledge of the Mental Capacity Act 2005 and the associated Deprivation of Liberty Safeguards was poor.

People were not supported to eat and drink enough to maintain a balanced diet.

some improvements had been made to the environment at the home since our last inspection and the provider was continuing with a programme of refurbishment and redecoration.

Is the service caring?

Requires Improvement

The service was not always caring.

Staff were kind, caring and considerate and had, over time, built a good rapport with people who they cared for.

People and, where appropriate, those close to them were not involved in the assessment and care planning process. This meant people may receive care that is not in line with their individual needs and preferences.

Staff showed concern for people's well-being, however they were not always quick to respond to people's needs.

Is the service responsive?

Requires Improvement

The service was not responsive.

People did not receive personalised care that was responsive to their needs.

Whilst the registered manager had been on an extended period of sick leave, no reviews of people's needs assessments or care plans had been undertaken.

The home did not employ an activities co-ordinator and there were limited activities provided at the home.

The service had not explored people's life histories, interests, hobbies or aspirations in order to provide opportunities to engage in meaningful activities.

Work was underway to improve needs assessments and care planning tools to gather more information about people who used the service so that a more personalised approach could be taken to the care that was delivered.

Is the service well-led?

Inadequate

The service was not well-led.

The service had not established robust systems to assess, monitor and improve the experience of people who used the service.

There was a poor atmosphere in the home during our inspection. there was little interaction between people who used the service and staff.

The registered manager and provider did not take a joined-up approach to the governance of the service.

The service had not submitted statutory notifications, as required by law.

Oakendale Residential Care Home

Detailed findings

Background to this inspection

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

The inspection was also carried out to follow up on breaches of regulations which we identified at our last inspection in June 2015 and in response to heightened concerns from the Local Safeguarding Authority.

The inspection took place on 29 & 30 October 2015 and was unannounced. This meant the provider did not know we would be visiting to inspect.

The inspection was carried out by the lead inspector for the service and an additional adult social care inspector.

Prior to our inspection, we reviewed all the information we held about the service which included intelligence we had been passed from the Local Authority and members of the public.

At the time of our inspection there were 11 people who lived at Oakendale Residential Care Home. During our inspection, we spoke with six people who used the service, two relatives, six staff and the Registered Manager.

We looked in detail at care records and associated documentation for five people. We also looked at a range of records relating to the management of the service. We spent time observing the environment and how staff interacted with people who used the service.

We spoke with service commissioners, the Local Safeguarding Authority and social workers during the

inspection to gain feedback about people's experiences of using the service.

Inadequate

Is the service safe?

Our findings

When we last inspected the service in June 2015, we identified breaches of regulations relating to staffing and safe care and treatment. The breaches were due to insufficient levels of staff to meet people's needs safely, medicines management, a lack of important information available for staff and the prevention and control of infections.

Following our inspection, the provider sent us an action plan which outlined how they planned to make improvements for people who used the service. During this inspection we checked what improvements had been made.

With regard to staffing, we found the provider had increased staffing levels, by adding one extra carer to the rota between 08:00 - 11:00 and 17:00 - 20:00, Monday to Friday. At all other times there were two care staff deployed to meet people's needs.

The home is split over three floors, with the main communal areas on the ground floor, bathroom and bedrooms on the first floor and bedrooms on the second floor. Due to the layout of the building, if staff members were providing care to people in their bedrooms, this left the communal areas unattended by staff. There were no call bells in the communal areas for people to use to summon assistance, which meant people could be waiting a significant period of time for assistance because of staffing levels. We observed this during our inspection.

We saw from records and staff confirmed that if people had to attend hospital, due to illness, the service was not able to provide a member of care staff to accompany them. For example, during the night of 28 October 2015, a person suffered a fall and began to have difficulty breathing. Paramedics were summoned and the person was taken to hospital. As there were only two members of staff on duty, the person had to attend the accident and emergency department alone. The person concerned suffered from vascular dementia and can become confused. They would have benefitted greatly from having a member of staff available to escort them to hospital.

The registered manager confirmed that staffing levels were not formally assessed against the dependency levels of people who used the service.

The above matters show that the provider had not ensured that sufficient numbers of suitably qualified, competent, skilled and experienced persons were deployed at all times. This was in breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During our inspection we interviewed two members of staff who were recently employed by the service. Both staff members confirmed they had been working 'shadow shifts', where staff observe care practices but do not engage in care interventions themselves and are supervised by substantive staff at all times, to familiarise themselves with the service. Both staff members confirmed that during these shifts there were times when they were left unsupervised.

During conversations with the staff members, they told us that they had not been asked to complete an application form, provide references or confirmation of Disclosure and Barring Service (DBS) checks, prior to undertaking the shadow shifts. The registered manager confirmed what the staff members had told the inspection team and added that the provider had taken responsibility for recruiting staff and that she was concerned that not all proper checks to ensure suitability had been undertaken prior to offers of employment.

This placed people at risk of receiving unsafe or inappropriate care from staff who were not suitable to work with people who, by virtue of their circumstances, may be vulnerable.

This was in breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because recruitment procedures had not been operated effectively to ensure persons employed at the service were of good character and had the qualifications, competences, skills and experience necessary to carry out their role.

We spoke with people who used the service and staff and also reviewed records relating to medicines to explore how the service managed people's medicines. We found the medicines management systems at the service were not robust and placed people at risk of not receiving their medicines as prescribed.

We looked at the controlled drugs register and spoke with staff about how controlled drugs were administered. Controlled drugs are medicines which may be misused and are protected by legislation. The controlled drugs register was not completed properly. It contained many errors and omissions, which included balance amounts, witness signatures and alterations without explanation.

We asked staff to explain the process they followed for administering controlled drugs. They told us that as they were on their own, apart from another member of staff who 'slept in' during the night, they would prepare and administer the medicine on their own, then ask the other member of staff to sign the witness column in the controlled drugs register when they woke in the morning.

The two staff that worked as 'sleep in' staff, had not received training on medicines administration and there had been no check on their competence to administer medicines safely. This showed the service did not follow national guidance and legislative requirements with regard to the safe and proper management of controlled drugs.

We observed how medicines were prepared and administered to people who used the service. We noted that there were three different versions of the service's medication administration policy contained in the front of the Medication Administration Records (MARs) folder. This could lead to confusion amongst staff about which policy they should follow.

MARs did not contain clear records of allergies, which meant staff may administer medicines to people, to which they may have an adverse reaction.

There were two people who used the service who chose to administer their medicines themselves. We found no risk assessments had been carried out in this regard. No person who used the service had specific care plans in place around administration of medicines. This left people exposed to risks of not receiving their medicines safely.

During our observations, staff displayed poor practice with regards to the administration of medicines. For example, staff signed MARs to say medicines had been given before they had administered them and staff

did not explain to people what the medicines were for.

There were people who used the service who required medicines to be administered at particular times of the day, as prescribed. For example, two people required medicines for Parkinson's disease to be administered early in the morning, in order that they could take effect to enable them to more easily control their condition whilst they were awake. One person told us that they sometimes received their medicines later in the morning. This meant their condition was not as easily managed, because they had not received their medicines as prescribed, which had a detrimental impact on their quality of life.

We looked at records of staff training and spoke with staff to find out what training had been undertaken with regard to medicines management. We found all staff who were employed at the time of our inspection, with the exception of the two night staff who worked as 'sleep in' staff, had received training in medicines administration. However, we found there were no formal observations or checks on staff competency that were completed. This meant the service could not be assured that all staff were following safe administration practices as checks had not been carried out. This left people at risk of receiving their medicines in a way that was not safe or appropriate for them.

We checked on how medicines were audited and managed by the service. The registered manager told us that a monthly audit was carried out by a senior member of staff. They were unable to provide a copy of the audit for August or September 2015. They admitted that the auditing systems around medication were not sufficient to ensure people received their medicines safely.

When we visited to feedback our inspection findings we were told that the service had implemented a daily check on medicines, to improve the safety of people who used the service. However, no documentation of checks that had been carried out was available to review.

The matters above constituted a breach of Regulation 12 (2) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the service had not established, and operated effectively, systems for the proper and safe management of medicines.

We spoke with people who used the service, staff and visiting professionals, as well as reviewed people's care documentation to see how the service managed risks to people. We found assessments of risk to individuals had not always been completed and where they had been completed, some were completed inaccurately. This left people at risk of unsafe care because staff did not have access to up to date guidance to help mitigate risks to individuals.

For example, we found one person had experienced numerous falls in the months prior to our inspection. We looked at their risk assessments and associated documentation and found that the person's written plan of care which helped mitigate the risk of falls had been written in December 2014 and had not been updated since. This showed the service placed people at risk because they had not ensured assessments of risk and associated management plans were regularly reviewed in order that they reflected people's current circumstances.

We reviewed care plans and associated documentation for another person. We found that they had been assessed by Speech and Language Therapists as being at risk of choking and required a soft, fork-mashable diet of a consistent texture, in order to minimise the risk to the person of choking.

When we reviewed the person's dietary intake records, we found that the service had provided the person with cornflakes on three occasions in the week before our inspection. This showed the service had

disregarded professional advice and placed the person at risk of choking. The service had placed the person at significant risk of serious harm.

The above matters constituted a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the registered person had not ensured risks to the health and safety of people were properly assessed and they had not done all that was reasonably practicable to mitigate any such risks.

We looked at how the service managed accidents and incidents which affected people who used the service. We reviewed accident and incident records and found there were no records whatsoever for October 2015 and one record of an accident in September 2015. When asked, the registered manager could not provide any explanation as to why accidents and incidents had not been recorded. This showed the service was not recording and analysing such events in order to maintain and improve the safety of people who used the service.

We were informed of a person who had suffered a fall on the evening of 28 October 2015 and had been taken to hospital. There was no record of this accident.

Similarly, when we reviewed the daily records for another person, we found numerous references to falls and the person being found on the floor in their bedroom during September and October 2015. This showed that occurrences where people's health and safety were affected, were not recorded and assessed appropriately so that measures could be put in place to minimise the risk of reoccurrence, which left people at risk of not receiving care and treatment in a safe way.

Along with the absence of up to date assessments and risk management plans mentioned earlier in this section, the matters above constituted a breach of Regulation 17 (2) (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the registered person had not maintained an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided and of decisions taken in relation to the care and treatment provided.

When we last inspected the service, we found there were strong mal-odours present in several areas of the home. We also found areas of the home which did not lend themselves to thorough cleaning and disinfection, which posed an infection control risk to people who used the service, staff and visitors. We also found the clinical waste bin, stored to the rear of the property was not kept locked, in line with national guidance.

During this inspection, we found the provider had begun a process of refurbishment at the home. The rooms where we found the strong mal-odours had had carpets replaced with non-slip, non-absorbent flooring which had dealt with the odours. The bathroom had been fitted with the same floor covering. We discussed the other areas of concern from our previous inspection with the registered manager and provider and were assured they were planned to be dealt with as part of the refurbishment.

This showed the provider had begun to make improvements with regard to infection control.

Training records showed and staff confirmed that they had undertaken training in relation to safeguarding people who may be vulnerable by virtue of their circumstances. This helped staff to know what forms abuse may take and how to recognise it. Staff told us they would not hesitate to report anything that gave rise to concerns about people.

Inadequate

Is the service effective?

Our findings

When we last inspected the service in June 2015, we identified breaches of regulations in respect of staff training, the application of the Mental Capacity Act 2005 (MCA) and the associated Deprivation of Liberty Safeguards (DoLS), consent to care and treatment, premises and nutrition and hydration.

During this inspection, we checked to see whether improvements had been made in the above areas.

We spoke with people who used the service, visiting professionals and staff, looked at staff training records and observed staff carrying out their duties to see whether people were supported by staff who had the skills, knowledge and experience to meet their needs.

We found there had been some improvements made with regard to staff training. Staff had completed courses in moving and handling, safeguarding adults, medicines administration and some staff had completed courses on the MCA. However, we found staff had not received training in essential areas, such as food safety, fire safety, infection control or dementia. Training courses had been planned for a number of staff in the near future which included fire safety, continence, food safety and training on the MCA.

We noted that the registered manager was still the only member of staff who had received first aid training. As they were only at the home between 07:00 and 15:00, Monday to Friday, this meant there was no first aid cover outside of these times.

This above showed that not all staff had the knowledge and skills necessary to support people effectively.

In addition, the registered manager confirmed that since they went on sick leave following our inspection in June 2015, no supervision sessions had been conducted for staff. Supervisions sessions are an important tool to support staff in their roles, by giving the opportunity for a confidential discussion about performance, training, aspirations and any obstacles to them completing their role effectively.

We discussed the MCA training with staff who had attended the course. From our conversations with them, it was clear the training had not enabled staff to fully understand their responsibilities in line with the Act. Staff were not able to demonstrate knowledge of the main principles of the MCA, nor how it would apply to their role in the care of people who used the service.

The above matters constituted a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the provider had not ensured staff had received such appropriate support, training, professional development, supervision and appraisal as was necessary to enable them to carry out the duties they were employed to perform.

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.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met.

We reviewed care plans and associated documentation for people who used the service. We found no records of people's consent to care and treatment, nor any assessment of people's capacity to make a decision around consent. The registered manager confirmed that the service did not formally undertake or record assessments of people's capacity prior to asking for consent to care and treatment.

The service had made one application under DoLS, which had not yet been reviewed by the Local Authority. Prior to this application, no assessment of the person's capacity had been undertaken, in line with the MCA code of practice and DoLS processes. The registered manager told us they were waiting for training to be able to carry out assessments of capacity in line with the MCA.

This showed the service was not working within the principals of the MCA. Additionally, the service had not sought and recorded people's consent to care and treatment. This was in Breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We spoke with people who used the service, staff and visiting professionals, as well as looked at records relating to nutrition and hydration. People we spoke with had mixed views with regard to the food supplied by the service. People told us they felt the food was 'cheap' and not of good quality. One person complained that because the bread the service used was "the cheapest they can get, so the sandwiches aren't very good". Other people we spoke with were content with the variety and quality of the food provided. One person told us; "I quite like the food, especially when [Staff] is on duty" Another said; "Can't grumble about the food".

We reviewed people's care plans and associated documentation with regard to nutrition. The daily records for one person included multiple references between late September 2015 and 29 October 2015 to them "not eating well" and "not wanting to eat". We saw a record dated 26 October 2015 which stated "Rang doctors to get [Name] an urgent referral to dietician". This showed the service had delayed seeking professional guidance, to assist in meeting the person's nutritional needs which put them at risk of receiving inadequate nutrition.

We reviewed the nutritional assessment for the same person, last reviewed in September 2015. The assessment stated "Low risk" and "[Name]'s food and fluid intake does not need monitoring". This was despite the person displaying poor appetite during September and October 2015 and having lost 5kg in weight since July 2015. This showed the nutritional assessment and associated care plan for this person was not reflective of their needs.

We saw another person had been experiencing poor appetite and weight loss, at least since July 2015. The person's nutrition care plan, dated 19 October 2015, did not state that staff should monitor the person's food and fluid intake, as would be expected in such a case. No detail was included in the care plan about whether the person required support to eat or drink. The person's nutritional care plan states they had been

prescribed food supplements which they should take each day. There was only one entry in the person's daily records between 19 September 2015 and 21 October 2015 to confirm this took place.

We asked to be provided with diet and fluid balance records for the person. The service was only able to provide a dietary intake record for week commencing 19 October 2015, which showed that on 20 October 2015, they had taken one "cup of tea" (no specified amount) in the morning, and "sips of warm water" and "sips of Ensure" during the afternoon. Ensure is a nutritional supplement, often prescribed to people who are at risk of malnutrition.

We also found a fluid balance chart for the person, dated 15, 16 and 17 August 2015. The chart was filled out incorrectly, with 'fluid intake' amounts recorded under 'urine output' for 15 and 17 August, with very little detail and was completely blank for 16 August. We were unable to locate and the registered manager was unable to provide any further fluid balance charts for this person. This showed the service had failed to adequately monitor the food and fluid intake of a person who is known to be at risk of not eating or drinking enough to maintain good health.

On reviewing the person's daily records, there are many references to the person not eating well, but other days they state "eaten and drank well". This is inconsistent with the person's nutritional care plan which states they have a poor appetite. Additionally, without actually recording food and fluid intake, it would be impossible for the service to judge whether or not the person had eaten well and taken enough fluids. This showed the service was not meeting this person's nutritional needs in a way that was designed to maintain good health.

The matters above constituted a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the nutritional and hydration needs of service users were not being met.

We saw some improvements had been made with regard to the premises. However, there was still more work that needed to be undertaken by the provider in order for the environment to be suitable. This work was underway at the time of our inspection.

The provider had begun a programme of redecoration and refurbishment at the home. A number of rooms were in the process of being redecorated during our inspection. The issues we highlighted at our last inspection, with regard to the fire escape and the broken furniture in the rear garden at the home had been resolved.

The provider was in the process of obtaining quotes to modify the ramp access at the rear of the property to make it more accessible for people who used the service. The provider was also in the process of looking into changing the patio and the paving surrounding the lawn, in order to reduce the risk of slips trips and falls for people who made use of the rear garden.

Requires Improvement

Is the service caring?

Our findings

People we spoke with told us the staff team were kind, caring and considerate. None of the people we spoke with raised any concerns about how staff treated people or their approach. People told us that staff respected their privacy and treated them with dignity. We observed staff interactions with people during our inspection and found them to be warm and compassionate. Staff were friendly, patient and were discreet when providing personal care interventions. However, due to staffing levels, interactions between staff and people who used the service were, for the majority, task-led or information giving.

A relatively small number of people lived at the home who were cared for by a consistent staff team. This meant that positive, caring relationships between people who used the service and staff were able to be developed. Staff we spoke with clearly knew people well and knew people's basic needs. People appeared comfortable in the presence of staff.

The service had not gathered information about people's life histories and preferences. People we spoke with told us that they were not involved in regular reviews of their care. Records we looked at confirmed this. We found care plans were not reviewed adequately, which meant information available to staff was often out of date and not reflective of people's current circumstances. This left people at risk of receiving care and treatment that was not in line with their needs or preferences.

There was very little evidence to show that people or those close to them, where appropriate, had any input into the care planning process. This meant people's views and opinions were not taken into account when their needs were assessed, or when their care was planned and delivered. This was in breach of Regulation 9 (3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During our inspection, we observed staff showed concern for people's well-being, however they were not always quick to respond to people's needs. Visiting professionals told us that whilst they had been supporting the service to improve, they had been having to prompt staff to assist people with caring tasks, such as helping people to the toilet or to change continence pads and to provide drinks.

We looked at how the service respected people's privacy and promoted their dignity. We observed staff discussed, within earshot of other service users and their relatives, sensitive personal information about other people who lived at the home. This showed the service did not respect confidentiality.

We found people's privacy was maintained during personal care interventions, for example, by closing doors and curtains. However, we found people were not always treated with dignity. For example, people and visiting professional gave us examples of cases where people had been waiting for assistance to go to the toilet and had soiled themselves because staff had not assisted them in a timely fashion.

This was in Breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, because people were not treated with dignity and respect.

The home did not have any links with advocacy services, nor was there any information available at the home for people who used the service on how to access such services. An advocate is an independent person who can represent someone's wishes and act in their best interests, without judging or giving their own opinion. Advocates can be very helpful to people who do not have anyone else to represent them, for example, someone who does not have regular visits from family members or friends. The lack of information and signposting to such services within the home meant that people who may have benefitted from the use of an advocate were unable to access them.

People and their relatives told us there were no restrictions on visiting times.

Requires Improvement

Is the service responsive?

Our findings

When we last inspected the service, we identified breaches of regulations with regard to the assessment of people's needs and care planning and the provision of activities. We received an action plan from the provider which outlined how they were going to make improvements for people who used the service.

During this inspection we checked to see whether improvements had been made.

We spoke with people who used the service, staff and visiting professionals, as well as reviewing people's care plans and associated documentation to see whether the service was responsive to people's individual needs.

During the inspection, we observed staff were responsive to people and anticipated their needs well. Staff told us they found their work satisfying and rewarding. However, it was difficult for staff to respond to people's needs in a timely manner due the number of staff on duty at any one time and having to perform other duties such as preparing food.

People did not receive personalised care that was responsive to their needs. People or those close to them, where appropriate, were not routinely involved in making decisions about their care. People told us and we saw care documentation which showed people's individual preferences were not explored and taken into account in the way care was delivered to them. There was no evidence available to show that people were involved in regular reviews of their care and treatment.

We found that whilst the registered manager had been absent for an extended period of sick leave, assessments of people's needs and written plans of care had not been reviewed for around three months. We looked at assessments of people's needs and associated care plans and found that in many cases they were not reflective of people's current circumstances. This showed the service was not responding to people's individual needs because staff did not have up to date guidance about how to provide care which met people's needs and preferences.

We looked at people's individual assessments and written plans of care which showed the service had not explored people's interests and aspirations with regard to how they liked to spend their time.

The home did not employ an activities co-ordinator at the time of our inspection. People, staff and visiting professionals told us that there were very few activities provided at the home. Examples of activities included; chair exercises, bingo, occasional trips out and occasional visits from performers. People told us they were not supported to go out into the community and that there main source of stimulation was the television. People were not supported to engage in activities that were meaningful to them.

The matters above constituted a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the service had not ensured they worked collaboratively with the person to deliver responsive care which met people's needs and reflected their preferences.

The registered manager was undertaking a piece of work to move all assessments and care plans to a new format which would capture more information about people's life histories, preferences, hobbies and interests. This was with a view to making the service more responsive to people's individual needs.

People we spoke with told us that they had not raised any formal complaints with the provider. They explained that if they had cause for complaint they would raise it through a relative or speak with the manager. The provider had implemented a formal policy and procedure to handle complaints. This was provided to people when they first moved in to the home. The service had not received any formal complaints in the last twelve months. We discussed the handling of complaints with the registered manager and were satisfied that they would handle formal complaints in line with the policy and procedure. This meant people could raise formal complaints with an appropriately senior person in the organisation.

The home had recently begun to hold resident's and relative's meetings again and were hoping to involve more people than had previously wished to participate. The provider was looking into different ways of gaining people's feedback in addition to conversing with them during time they spent at the home.

Inadequate

Is the service well-led?

Our findings

When we last inspected the service, we identified breaches of regulations in respect of assessing, monitoring and improving the service, as well as statutory notifications.

We received an action plan from the provider which outlined how they planned to make improvements for people who used the service.

During this inspection we checked to see whether improvements had been made.

We reviewed the governance systems at the service. We did not find any written documentation to show that the manager or service provider had properly established any robust monitoring systems. There were no effective audit systems in place to monitor areas such as care planning, medicines management, health and safety, risk assessments or cleanliness and infection control.

During the inspection, the registered manager confirmed the only audits undertaken by the service were medicines and infection, prevention and control (IPC). During further discussions, it came to light that the IPC audit had not yet been completed, despite the service commencing the audit in September 2015. The registered manager told the inspection team that the medicines audit was carried out monthly, by a senior member of staff, but was unable to provide any documentation to demonstrate the audit was carried out. The issues highlighted above, with regards to medicines management led us to question the efficacy of the medicines audit. The Registered Manager confirmed no other audits had been implemented to monitor the quality of the service.

The inspection team observed a poor atmosphere in the home across both days of inspection, with the communal areas populated by people and staff who seldom interacted with each other. We did not observe many examples of staff trying to engage with people who used the service or lift the atmosphere. There was no evidence of good leadership by senior staff to improve the experiences for the people who lived there.

We received concerning information during the period that the registered manager was on extended sick leave from the local authority. Concerns centred on a lack of leadership and governance during the absence of the registered manager. The concerns included; staff describing themselves as "muddling through" without the registered manager, no audits or safety checks being carried out and assessments of people's needs and care planning documentation not being reviewed.

This demonstrated poor governance within the service, which put people at risk of receiving care that was not of an adequate standard.

We requested documentation of staff team meetings that had been undertaken previously. The registered manager told the inspection team that she did not have these available, but would request a copy from the provider. We requested the documentation from the provider, who told us that the minutes were with the registered manager, waiting to be typed up.

The registered manager told us that they did not feel they got enough support from the provider. They gave examples of management tasks that the provider had taken responsibility for which included staffing rotas, food ordering, staff supervision and recruiting new staff. They told the inspection team that because they did not have input into these areas, they felt "out of the loop". They explained that they had not felt supported by the provider since before they went on sick leave in June 2015.

We discussed the above point with the provider. They explained that they had taken responsibility for some management tasks to give the registered manager, time to complete more important tasks relating to improving peoples' care planning, risk assessments and audits.

The above points showed a conflict between the registered manager and the provider, which raised concerns about leadership and governance at the service, because of the lack of a joined-up approach between key levels of management.

Across the inspection dates, we reviewed a range of documents and records relating to people's care and the management of the service. Records we looked at were not always accurate and up to date. For example, people's risk assessments and care plans were not always reflective of their current circumstances and needs. Additionally, records relating to the management of the service, for example, staff meetings were unavailable for review.

Daily records, a contemporaneous record of care delivered, for each person were not recorded in detail. Staff who completed the records often did not include times that care was provided, for example, personal care or professionals' visits. Notes were often very brief such as; "[Name] fine at the time of writing this report"; "Eaten and drank well, no new concerns".

Care planning and risk assessment documentation, which contained confidential personal information, was kept in an unlocked cupboard in the dining room at the home.

This showed the service did not maintain securely an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided.

The above matters constituted a breach of Regulation 17 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

During the period from June 2015 to September 2015, the registered manager was on extended sick leave, followed by annual leave. We were not notified of this absence by either the registered manager or service provider, as was required, via statutory notification. The service had not submitted other statutory notifications, as required, with regard to other significant events at the service, including accidents and incidents which affected people who used the service.

This was in breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents The service had not submitted statutory notifications as required.

The enforcement action we took:

The service has been rated as Inadequate overall and in line with our guidance has been place into special measures. Where we identified a breach of regulation during inspection which is more serious, we took action to keep people safe. We will report on any action when it is complete.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care People's views and opinions were not taken into account when their needs were assessed, or when their care was planned and delivered. The service had not ensured they worked collaboratively with the person to deliver responsive care which met people's needs and reflected their preferences.

The enforcement action we took:

The service has been rated as Inadequate overall and in line with our guidance has been place into special measures. Where we identified a breach of regulation during inspection which is more serious, we took action to keep people safe. We will report on any action when it is complete.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People were not treated with dignity and respect.

The enforcement action we took:

The service has been rated as Inadequate overall and in line with our guidance has been place into special measures. Where we identified a breach of regulation during inspection which is more serious, we took action to keep people safe. We will report on any action when it is complete.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent

	The service was not working within the principals of the MCA. Additionally, the service had not sought and recorded people's consent to care and treatment.

The enforcement action we took:

The service has been rated as Inadequate overall and in line with our guidance has been place into special measures. Where we identified a breach of regulation during inspection which is more serious, we took urgent action to keep people safe. We will report on any further action when it is complete.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The service had not established, and operated effectively, systems for the proper and safe management of medicines. Risks to the health and safety of people were properly assessed and they had not done all that was reasonably practicable to mitigate any such risks.

The enforcement action we took:

The service has been rated as Inadequate overall and in line with our guidance has been place into special measures. Where we identified a breach of regulation during inspection which is more serious, we took action to keep people safe. We will report on any action when it is complete.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs The nutritional and hydration needs of service users were not being met.

The enforcement action we took:

The service has been rated as Inadequate overall and in line with our guidance has been place into special measures. Where we identified a breach of regulation during inspection which is more serious, we took action to keep people safe. We will report on any action when it is complete.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered person had not maintained an accurate, complete and contemporaneous record in respect of each service user, including the a record of the care and treatment provided and of decisions taken in relation to the care and treatment provided. Systems to assess, monitor and improve the quality of the service provided were not operated effectively.

The enforcement action we took:

The service has been rated as Inadequate overall and in line with our guidance has been place into special measures. Where we identified a breach of regulation during inspection which is more serious, we took action to keep people safe. We will report on any action when it is complete.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed Recruitment procedures had not been operated effectively to ensure persons employed at the service were of good character and had the qualifications, competences, skills and experience necessary to carry out their role.

The enforcement action we took:

The service has been rated as Inadequate overall and in line with our guidance has been place into special measures. Where we identified a breach of regulation during inspection which is more serious, we took action to keep people safe. We will report on any action when it is complete.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had not ensured that sufficient numbers of suitably qualified, competent, skilled and experienced persons were deployed at all times. The provider had not ensured staff had received such appropriate support, training, professional development, supervision and appraisal as was necessary to enable them to carry out the duties they were employed to perform.

The enforcement action we took:

The service has been rated as Inadequate overall and in line with our guidance has been place into special measures. Where we identified a breach of regulation during inspection which is more serious, we took action to keep people safe. We will report on any action when it is complete.