Oakwood Care Centre Limited

Oakwood Care Centre

Inspection report

400a Huddersfield Road
Millbrook
Stalybridge
Cheshire
SK14 3ET

Tel: 01613032540
Website: www.oakwoodcarecentre.co.uk

Date of inspection visit:
14 December 2017
18 December 2017
22 December 2017

Date of publication:
25 June 2018

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

We carried out an unannounced inspection of Oakwood Care Centre on 14 December 2017 and undertook announced visits on 18 and 22 December 2017.

Oakwood Care Centre is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Oakwood Care Centre is situated in Stalybridge, Tameside. The home is registered with CQC for up to 18 people and at the time of the inspection provided care, support and accommodation to 15 people who required personal care without nursing.

The home is a two storey detached building providing bedrooms and lounge/ dining area on each floor. Communal bathrooms and toilet facilities are available throughout the home. The kitchen is at the rear of the building. The home has a laundry and boiler room located in the basement.

The home was last inspected on 09, 10 and 11 January 2017 when we rated the home as inadequate overall and identified nine breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These were in relation to; person-centred care, need for consent, safe care and treatment safeguarding service users from abuse and improper treatment, receiving and acting on complaints, good governance, staffing, fit and proper persons employed and notifications of other incidents.

The overall rating for the service was 'inadequate' and the home was placed in to special measures.

Services in special measures are kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, are 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. 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 re-inspect it and is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

Following the last inspection, we issued warning notices for safe care and treatment and good governance which identified a timeframe that the service needed to be compliant with the regulations by. We also asked the provider to complete an action plan to show what they would do and by when to improve all five of the key questions (safe, effective, caring, responsive and well-led). We also met with the registered provider to discuss the inspection findings and the requirement to improve the overall quality of the care provided at Oakwood Care Centre to at least a rating of 'Good'.

During this latest inspection we found the necessary improvements had not been made and there were continued systemic failures across the home. The overall rating for this inspection is inadequate which means the service will remain in special measures. You can see what action we told the registered provider to take at the back of the full version of the report. Full information about CQC's regulatory response to the more serious concerns found during inspection is added to reports after any representations and appeals have been concluded.

At the start of the inspection, the service had a registered manager in place who had registered with CQC in October 2017. However, whilst the inspection was underway they were in the process of working their notice and subsequently completed their notice period on 18 December 2017. Following the inspection, CQC received the registered manager's application to de-register from the service. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The registered provider had asked the deputy manager to step up to the manager position whilst the registered manager was working their notice and the deputy manager had been managing the service for a week when we undertook our first inspection visit on 14 December 2017. For the purpose of the report, we have referred to them as the manager. The manager told us it was their intention to register with CQC and to become the registered manager but at the time of the inspection they had not commenced the process.

We found the service was not safe. We identified serious concerns regarding the management of environmental risks. There were no window restrictors on windows which posed significant risks to people. We raised this with the registered manager during our second inspection visit and this was addressed whilst we remained on site. We expressed concerns regarding the fire alarm system which had been recommended for replacement during the fire risk assessment conducted in December 2017. Following the inspection, we received an update to inform us that a new system had been installed. Other environmental concerns identified included; dirty water running under open baskets containing clean laundry, clean laundry being stored where staff smoke which was a fire risk and we identified a steep stairwell with only a small bar to prevent people access which was a risk to people's health and safety.

We found accidents and incidents were recorded but documentation contained limited information to enable analysis to determine trends and prevent re-occurrence.

Medicines were not managed safely. We found sufficient times had not been maintained between doses of medicines as per prescribers and manufacturer's instructions. At the start of inspection people did not have 'when needed' (PRN) protocols or cream charts in pace to support administration and application. We saw these were implemented by our second inspection visit.

Staffing levels were not calculated using a formal calculation based on the needs of people using the service. We observed people were left unattended during the inspection for significant periods of time.

The service was not complying with the requirements of the Mental Capacity Act (2005) and the Deprivation of Liberty Safeguards (DoLS). Mental Capacity assessments were not conducted. The management had no oversight as to when Deprivation of Liberty Safeguard authorisations had been requested or granted. We found two granted authorisations which had expired and applications had not been re-submitted within required timeframes.

People were supported to have enough to eat and drink but told us choices were limited. We observed people eating their meals on their knees because there were insufficient dining tables and chairs to accommodate all the people living at the home.

We saw people were treated in a caring and respectful manner but noted staff did not engage with people when they had the opportunity. Staff interactions were task focused and when the intervention was completed, staff sat together chatting and didn't initiate conversation with people living at the home.

The service was unable to demonstrate how people, who used the service, or their representatives, were encouraged to contribute to the planning and reviewing of their care.

We found there were few opportunities to engage in activities and people were seen sitting in the lounges or their bedroom with no meaningful activity or positive interaction taking place. People had expressed in a survey, they would like the opportunity to go on trips but this had not been addressed by the registered provider.

We found there was no effective system in place to monitor and plan improvements to the service provided. A survey had been conducted but this had not been analysed and we found people had made suggestions and requested things but this had not been considered or addressed.

The service was not well led. The registered provider did not demonstrate oversight of the service and did not have a system in place to assess the quality of the service. There were limited audits carried out by the registered manager and when the registered manager had identified areas that needed improvement, the registered provider had not responded or taken action to address these. We found the registered provider made changes and addressed areas of concern whilst we were on site but did not demonstrate sufficient oversight to identify concerns internally or address them without our input.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe

People were not protected from environmental risks. Risk assessments had not been completed to identify risks or control measures implemented to manage risks to people's health and safety.

Not all accidents and incidents had been properly recorded. The ones, that had been recorded were not analysed to identify any patterns or trends to help prevent them from happening again.

Medicines were not managed safely as sufficient time between doses was not maintained.

Staffing was not calculated based on people's dependency and we observed people were left in communal areas with no staff presence for long periods of time.

Is the service effective?

Requires Improvement

The service was not effective

Staff had not received the training, support and supervision needed to enable them to support people effectively.

Mental capacity and restrictive screening assessments had not been carried out. Deprivation of Liberty Safeguards had been authorised but subsequently expired.

People had signed when appropriate to do so to consent to their care.

People were supported to have enough to eat and drink but food choices were limited. People's dining experience was effected as there were insufficient dining facilities to enable people the option of sitting at a dining table to eat their meal.

Is the service caring?

Requires Improvement

The service was not consistently caring.

Staff did not engage with people when they had the opportunity. Staffing arrangements meant care was task focused and not focused on people.

It was not evident from support plans how people had been engaged and involved in making decisions about their care.

Suitable bathing and showering facilities were not available.

We observed some positive interactions and people spoke fondly of staff.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Opportunities for people to be involved in planning and reviewing their care could not be demonstrated.

People were not supported to participate in social activities within the home and the local community. Opportunities for people to follow their interests or be involved in social activities were limited unless they were mobile and able to engage without support.

There was no effective system in place for logging and responding to complaints.

Is the service well-led?

Inadequate

The service was not well-led.

The registered provider had failed to comply with the warning notice or requirements following our last inspection. This meant people had continued to experience poor and unsafe care.

The registered provider did not demonstrate oversight of the home and did not have systems in place to assess, monitor or to support the service to improve.

People's views on the service were gathered but action was not taken to use the information to improve the quality of care provided.

Oakwood Care Centre

Detailed findings

Background to this inspection

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

This inspection took place on 14 December 2017 and was unannounced. We undertook two further inspection visits on 18 and 22 December 2017 and these were announced.

The inspection team consisted of one adult social care inspector from the Care Quality Commission (CQC).

Prior to the inspection the service completed a Provider Information Return (PIR), which is a form that asks the registered provider to give some key information about the service, what the service does well and improvements they plan to make. We also reviewed all the information we held about the service including statutory notifications and safeguarding referrals.

We made contact with the local authority quality performance officers, safeguarding, environmental health and infection control to ascertain if they had information to support our inspection planning.

As part of the inspection, we spoke with four people living at the home and one visitor. We also spoke with; the registered provider, registered manager, manager, deputy manager, two care staff and one visiting health professional.

We spent time looking through written records, which included three people's care records, four medicine administration record (MAR), six staff personnel files and other records relating to the management of the service.

Inadequate

Is the service safe?

Our findings

People living at Oakwood Care Centre and one visiting relative spoken with during the inspection didn't express any concerns regarding the safety of the home.

At our last inspection we identified concerns regarding the identification and management of environmental risks and infection control practices at the home. At this inspection we identified further concerns.

People were not protected from the risk of sustaining burns from hot surfaces. The Health and Safety Executive (HSE) states 'Contact with surfaces above 43 °C can lead to serious injury'. We saw one person had a heater in their bedroom which was in a poor state of repair. The person had purchased the heater themselves and we were told they were insistent on having the heater on daily. We found there was no risk assessment in place, maintenance checks had not been completed and there was no agreement for repairs. We identified this during the inspection and a risk assessment was implemented. When we visited the home 22 December 2017, we noted the heater had been replaced.

We found people were not protected from the risk of falling from heights. Windows on the first floor were not restricted and consequently opened far enough to allow a person's body to pass through. Some people living on the first floor had reduced mental capacity and / or significant mental health needs which may have impaired their judgement or ability to maintain their own safety. We saw one person's window on the lower floor was at chest height and was situated above a steep stairwell. There were no risk assessments in place in relation to the window openings. We found window restrictors were not in place in another person's room and this presented a significant risk to this person due to their care and support needs. The failure to consider the risks posed by windows placed people at serious risk of harm.

During our visit on 18 December 2017, we identified the seriousness of the issue and the registered manager went to the local hardware store to obtain materials. There was no handyman employed by the provider and no contractual arrangements in place to ensure a prompt response. However, the senior carer arranged with a handyman they knew to attend the home that afternoon. We sent the deputy manager the HSE guidance relating to 'falls from windows or balconies in health and social care' for reference to the control measures to manage the risk. Prior to us leaving Oakwood Care Centre following our second visit, window restrictors had been fitted.

We observed there was a bedroom located next to a steep staircase that led up to the agency office in the attic. There was no door blocking access to the stairs and there was just a small bar used to discourage people from accessing the stairwell. The bedroom adjacent to the stairs was not in use at the time of the inspection but there was nothing preventing other people living at the home accessing this area. The bar was not sufficient to deter people and could increase the risk of serious injury if a person was to attempt to go up the stairs and subsequently fell. There was no risk assessment in place to determine this risk had been identified or the control measures in place to reduce the likelihood of occurrence or significant event.

People were not adequately protected from the risk of fire. The fire risk assessment dated 20 December 2017; documented eight recommendations that were rated high and needed immediate priority to be actioned within 24 hours to eight weeks. We saw the target completion date was 20 February 2018. Following our inspection, we received an action plan confirming all the recommendations would be completed in January 2018; however one recommendation which involved fitting intumescent smoke seal strips to all the fire doors was proposed for completion of five doors per month from January to June 2018 which meant this would not be completed in the identified timeframe.

We noted in the fire risk assessment it had been documented smoking was not permitted on the premises. However, we observed staff accessing the basement and returning with a strong smell of cigarettes. We asked the management who acknowledged the staff had been accessing the basement as an unofficial smoking area. This had not been considered as part of the fire risk assessment and there had been no service risk assessment. The boiler was situated in the basement, there was a sign displayed which stated 'flammable items must not be placed on top of the boiler'. Furthermore, the basement was used as a laundry facility and contained bedding, towels and other combustible items which could facilitate the spread of fire. We informed the manager of our concerns and following the inspection we were told the basement was no longer used as a smoking area for staff.

During our previous inspection we found concerns about the cleanliness of the home and measures in place to prevent and control the spread of infection. Prior to undertaking the inspection, we were informed the home had scored 93% on the last infection control audit. During the inspection we identified continued areas of concern. We observed in the basement, there were two washing machines and a tumble dryer. We observed clean and dirty washing were kept in open laundry baskets. We saw the floor was wet as the drainage system runs through the basement and there was a stream of dirty water going under the clean laundry baskets. We raised this with the manager as a concern and the registered provider told us they were in discussions to undertake a full environmental audit to identify and prioritise areas of risk.

During this inspection we found the downstairs lounge carpet had an unpleasant odour. We noted this over the three days of inspection and raised this with the management. The manager confirmed there was a domestic member of staff that worked at the home daily, seven days a week and they regularly deep cleaned the carpet but the smell returned. We saw an infection control self -audit tool completed as far back as October 2016 had identified the back lounge carpet and worn chairs needed replacing. We asked the manager if the carpet had been changed since this audit had been completed and they confirmed the carpet had not been replaced for over 10 years. A visitor also told us; "The downstairs carpet is badly stained and smells. They are not very good at wiping the tables down either. They just set the cutlery down for the next meal without wiping the food debris away from the last meal."

Whilst completing a walk round of the premises, we saw in one of the bedrooms there had been a ceiling leak from the upper en-suite bathroom. The leak had been repaired but it had left an unsightly stain. We found hairbrushes, shaving foams, deodorants, talc powder, shower gels and bars of soaps left in bathrooms. Hand wash posters were not displayed in all the bathrooms. At our last inspection, we identified the bath lift in the first floor bathroom did not have arm rests or the required safety straps and was still in place over the bath. There was no warning information displayed to ensure this was not used and meant there was a continued risk it may be used without the necessary safety belt.

At our last inspection and during this inspection, we found that people did not always have a working call bell in their bedroom. This meant people would not be able to request assistance from staff when requiring urgent help or that people may be unable to summon assistance if help was needed. We raised our

concerns with the manager and they ordered call bells during the inspection. We saw these were available when we undertook our second inspection visit.

We found continued concerns with the oversight of accidents and incidents occurring in the home. As part of our inspection we looked at how accidents and incidents were recorded, analysed and acted upon. We were told accidents and incidents were recorded on specific forms kept in the home manager's office but these were unable to be found during the inspection. We asked whether an analysis of what had occurred was carried out to establish whether there were any contributory factors that could be identified. For example, the exact location, time, details of the incident, footwear, environmental factors, staff present, any medical factors that could increase the risk of incident. We were told an analysis was not completed to identify trends to implement control measures to prevent re-occurrence. We saw control measures had been put in place on an individual level and a person who had experienced a number of falls had been referred to the falls team, an alert mat had been put in their room and the furniture had been moved to reduce the risk. However, they were also identified as having a medical condition that had not been explored with their GP as to what this meant for them and what the risks entailed.

At our last inspection, we found concerns regarding the safe storage and administration of medicines. At this inspection we identified ongoing concerns with the administration of medicines. We saw there was a medicines policy dated January 2016 and we were told staff had completed Social Care TV medicines training. We also saw staff administering medicines had completed pharmacy training in November 2017 and had been issued with certificates to verify this. Medicine trolleys were anchored to the wall in the lounge but temperatures weren't checked to ensure medicines were stored in line with safe storage of medicines guidance to ensure the room temperature did not exceed 30C as this could affect the efficacy of the medicines.

We looked at administration records for pain relief and saw people were not receiving their medicines as prescribed and the home did not have suitable arrangements in place to demonstrate sufficient times were being maintained between doses.

At the start of the inspection we asked whether staff administered PRN , this is medication given as and when required such as Paracetamol to relieve pain. We found that all medicines prescribed in that way did not have adequate information available to guide staff on to how to give them. When people were prescribed creams there was little or no information available to guide care staff as to where or how often to apply them. We saw management had addressed this by our second visit at the service and PRN charts and cream application records had been implemented.

This meant there had been multiple breaches of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014; safe care and treatment because; the registered provider could not demonstrate they were assessing the risks to the health and safety of service users receiving care or treatment. The registered provider had not ensured the safety of the premises or assessing the risk of, and preventing the spread of infections. Medicines were not managed safely.

During the inspection, we looked at how the registered provider ensured there were sufficient numbers of staff on duty to meet people's needs. We were told by the registered manager, staffing levels were not calculated using any formal method based on people's dependency. The staffing compliment during the day Monday to Friday consisted of one senior, two care staff, a domestic, cook and the manager. At night, there was two care staff on duty. Staff told us; "I feel there is enough staff when we have one senior carer and two care staff in the day and two care staff at night. Most people are able to tell you what they need." A visitor told us; "I don't think there are enough staff. There are three staff but there are two floors which

means the lounge is left unattended and people are on their own with no staff about. I've had to go and find staff because people get up and I have observed them fall."

We observed deployment and oversight of the staff was not effective as staff took their break at the same time or went in to the basement of the home together which impacted on the availability of staff in communal areas. During our second inspection visit, we observed three people sat in the upstairs lounge but there was no staff present or in the vicinity of the lounge. We observed the lounge for five minutes and during this time one person swore at another person and was sticking their fingers up at them which caused the other person to shout back. This could escalate further and result in safeguarding issues which the staff would be unaware of as they were not present.

We also expressed concerns regarding staffing numbers and fire safety. We saw there was two staff on duty at night which meant if there was an emergency event such as fire there would only be two staff on duty to manage this situation and ensure people's safety. We found the provider could not demonstrate this had been considered and although fire drills had been conducted, these had only been facilitated during the day when there was more staff available and not a true reflection of the night staff compliment.

We recommend the provider carries out an assessment of people dependency, to determine there are sufficient numbers of staff deployed during the day and night to meet the care needs and environmental risks that could arise.

At our last inspection, we asked for the safeguarding policy but this could not be provided and we found only 50% of staff had received safeguarding training. We identified safeguarding concerns had also not been reported to CQC. At this inspection, we were given the safeguarding policy and procedure and there was a safeguarding flow chart for reference identifying who to contact if a safeguarding matter arose. We saw there were still gaps in the training but this had improved since our last inspection. We spoke with staff and they were able to identify safeguarding concerns. A staff member said, "I've had safeguarding training. A safeguarding issue could be abuse, not attending to a person's personal care, neglect, financial abuse, raising voice or using your power over the person. If I had any concerns I'd report what I'd seen to the senior on duty or the manager." A second staff member told us; "Safeguarding matters could be physical, neglect, not following moving and handling procedures, people over sedated, if people had bruises. I'd report to my manager but if they didn't report it I would follow whistleblowing policy." We saw there were no safeguarding referrals in the safeguarding file; however we were informed of a recent safeguarding matter that had been raised by a visiting health care professional regarding restrictive practice. CQC had not been notified of this in line with the requirements of the providers' registration. We are considering this matter further.

We found people had a Personal Emergency Evacuation Plan (PEEP) in place. A PEEP provides information on accessibility and means of escape for people documenting there mobility, assistance needs and ability to understand and respond in the event of an emergency. The PEEPs described the care and mobility needs of each person, documented personal information, contacts and GP information. However, we found they referred to the previous regulations and the social care act 2008 (Regulated activities) Regulations 2010 which were superseded by the 2014 Regulations.

We saw the safety and servicing certificates were in date as these had been raised as an issue at our last inspection and addressed whilst the inspection was underway. We noted there was no internal mechanism to identify when maintenance and safety checks were required. We noted the bath hoist needed servicing in

November 2017 and at the time of the inspection this had still not been done.

At our last inspection we found an issue with recruitment records. Paperwork was disorganised and staff did not have personnel files. We found the provider could not demonstrate safe and robust recruitment checks had been completed as some staff working at the service unsupervised did not have Disclosure and Barring Service (DBS) checks in place. At this inspection, we found staff had personnel files which were organised and stored in a filing cabinet in the attic of Oakwood Care Centre. We looked at six recruitment files at this inspection and found recruitment practices had improved but required further strengthening to ensure there were no gaps in procedure. We saw one staff member had a DBS check that had been completed by their previous employer but there had been no further checks completed upon commencing in employment at Oakwood Care Centre. One staff member had only a basic disclosure on file and not an enhanced disclosure and one staff member had no picture identification to verify their identity. We also noted staff working at the care agency in the attic of Oakwood Care Centre had full access to the home but did not have DBS checks in place.

This was a continued breach of regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following the inspection, the registered provider contacted us to inform us the necessary DBS checks had been completed. This included for staff working in the nursing agency. This will be followed up at our next inspection.

Requires Improvement

Is the service effective?

Our findings

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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation 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 spoke with the registered manager at the start of the inspection and they expressed some ambiguity regarding whose responsibility it was to assess people's capacity. The registered manager acknowledged they had not been completing mental capacity assessments or restrictive practice screening tools. These assessments are required to determine whether a person may be subject to a deprivation of their liberty and require authorisation from the local authority.

We asked the registered manager at the start of the inspection who was subject to a DoLS. The registered manager identified five people living at the service. We noted 'DoLS' was written next to people on a white board in the office which was visible to people and visitors to the home when accessing the manager's office which didn't maintain confidentiality. We told the registered manager and they rubbed this off the board during our first inspection visit.

During our last visit to the service, we asked the manager for the DoLS matrix and DoLS authorisations. The manager was unaware of a matrix and was unsure where the authorisations were kept. The manager looked in the DoLS file but there was no matrix to demonstrate oversight of submitted requests or granted authorisations. We saw there were two granted authorisations filed but they had both expired. We looked in people's care files but there was no information contained. The registered manager had left the service by this time and when the manager tried to contact them for support, they were unobtainable.

The Local Authority states that an application should be made at least 14 days prior to the expiry of the authorisation if the person is still identified as having their liberty restricted. This had not been done. There was no central system to monitor the submission of standard authorisation and the expiry of granted applications. The Care Quality Commission is required by law to monitor Deprivation of Liberty Safeguards and to report on what we find. The Deprivation of Liberty Safeguards provides a legal framework to protect people who need to be deprived of their liberty in their own best interests. The manager contacted the local authorities to establish who had a granted authorisation and resubmitted applications for those people that required a DoLS but it had expired. A matrix was also devised to maintain oversight proceeding forward.

This was a breach of Regulation 13 (5) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014; safeguarding service users from abuse and improper treatment.

We looked at the induction programme. The care certificate was not in place. A basic service induction was undertaken which involved familiarising new staff with the service. However, we found there was no timeframe in place for new care staff to complete mandatory training as part of an induction process.

The care certificate assesses the fundamental skills, knowledge and behaviours that are required to provide safe, effective and compassionate care. It is awarded to care staff when they demonstrate that they meet the 15 care certificate standards which include; caring with privacy and dignity, awareness of mental health, safeguarding, communication and infection control. We saw six staff had been enrolled on the Health and Social Care NVQ 3.

We looked at whether staff received continued support, such as; training, supervision and personal development, to enable them to effectively fulfil their duties. We found supervisions had taken place but not consistently and supervision records indicated they had last been completed in May 2017. There was no schedule in place to ensure regular supervision and no appraisals had been completed. We raised this with the manager and they commenced completing supervisions and completed 10 supervision meetings whilst the inspection was on-going.

We also found regular competency checks were not being completed for all staff and the only competency assessments completed were medicine competency assessments which were available for three staff. We saw a medication competency checklist which identified one member of staff had not always been compliant but we could not establish what support or additional training had been provided or whether the staff member had been reassessed as being competent.

We saw staff personnel records had improved and were now organised. However, the training matrix had not been regularly updated to demonstrate continued oversight of staff training. We were given a training matrix during our first inspection visit but were informed it needed updating. We asked for this to be completed and we received the updated matrix on 27 December 2017. We saw there were gaps in the training completed. We saw only two staff in addition to catering staff had completed food safety and catering. This is of particular concern as the chefs only worked at the service until 14.00 which meant care staff were responsible for the evening meal and supper. Other gaps on the training matrix included; safeguarding, health and safety, moving and positioning and DoLS. We noted no staff had received MCA training, Dementia or Mental Health despite people living at Oakwood Care Centre with these needs.

This was a continued breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Staffing.

We saw people had consented to their care and had signed to consent to; assist with delivery of care, support plans, medicines, care choices, sharing of relevant information about care and well -being with appropriate health and care professionals and photographs. When people were deemed not to have capacity to consent to their care, consent was sought in people's best interest by their next of kin.

During this inspection we reviewed people's personal care files to check if people were supported to maintain their health and well-being. We saw people had access to; continence team, Speech and Language Therapy (SaLT), GP, and District Nurse's, fall's team, podiatrist and mental health team. This meant people's healthcare needs were being met.

We saw people's weights were monitored but there was no record of people's height to calculate their body mass index (BMI) to determine the requirement to refer people to dietetic services. However, we noted referrals had been made as required and two people were awaiting assessment from the dietician for support. At the start of our inspection the service did not complete malnutrition universal screening tools (MUST) to calculate people's nutrition risk or waterlow risk assessments to determine people's risk of skin breakdown. We raised this on the first day of our inspection and found these had been completed for all the people in the service by our second inspection visit. We did not find any concerns whilst undertaking the inspection and were satisfied the implementation of these risk assessment would highlight any issues or concerns proceeding forward.

At the time of inspection, there was one person who was receiving input from the district nurses as they had a sore on their hip. We saw the person had the required equipment in place, profiling bed and an up to date skin integrity plan. The person was also receiving appropriate repositioning support to reduce the risk of skin breakdown.

On the day of our inspection, the home was awarded five for food safety.

At the time of inspection there was nobody receiving a special diet. We saw one person had been referred to SaLT because they were spitting out lumps so in the interim whilst awaiting assessment, staff were providing foods with softer textures and no lumps to encourage eating as they were also losing weight and awaiting dietetic assessment.

The home had two chefs working until 14.00 but the kitchen remained unlocked for staff to access and prepare meals. We were told breakfast was whatever people wanted and lunch was a hot meal and the evening meal was either a meal prepared in a slow cooker, a pasta dish, soups and sandwiches. Supper was crumpets, biscuits, sandwiches, chips or pizza. A visitor told us; "The food always smells good. There's a new cook and the food has got much better. [My relative] isn't a big eater but they do try and encourage them with foods they prefer." A person told us, "The food is fine. It's just enough for me. I've had some nice meals. I like toast and a coffee for my breakfast and I get that." A second person said, "There isn't much choice at mealtimes. You have to wait half hour or so to get breakfast."

We saw there were no menus on display and the management could not demonstrate how people had been engaged with devising menu plans. We also noted four survey responses all mentioned the food, documenting; "Veg too hard," "No choice." "Would like more fish" "Would improve more if catered for the individual." The management had not analysed the survey responses so were unaware these comments had been made. This meant action had not been taken to improve people's experience or to respond to the concerns raised.

We found that the design of the building was not in line with current national practice guidance for people living with dementia. There was no signage to orientate people to communal areas', bathroom facilities or bedrooms. The home was not designed to enable people to navigate their way round independently and reasonable adjustments had not been made in line with current legislation and guidance.

Requires Improvement

Is the service caring?

Our findings

The people we spoke with during the inspection told us the staff were kind and caring. One person said; "The staff are all nice." A second person said; "The staff are alright, there is nothing wrong with them. They are always helpful." A visiting health professional told us; "The staff are a credit to the home." A visitor said; "I picked this home because it's friendly, small and looked homely. I think the care is good. It's not bad. Some staff are more willing than others."

We found there were widespread and significant shortfalls in the home, which meant peoples' immediate and on- going needs were not consistently met to demonstrate a caring culture. Whilst we found some staff had good intentions, they were not supported by the registered provider or systems in the home to ensure people were kept safe. Although people told us the staff were caring, the registered provider failed to identify and act on risks which meant procedures were not followed to ensure people received safe, effective care and treatment.

Some practices at Oakwood Care Centre were not person- centred or considered in the interest of people living at the home. During the course of our inspection we saw an email had been sent between the registered manager and registered provider regarding works needed. The email was in regards to the upstairs bath taps needing repair. The registered manager identified the bath taps had not worked since they had commenced working at the home. The registered provider had responded by asking if the fault had been identified at inspection and had not enquired about the impact on the people living at the home. The registered manager had commenced at the home in January 2017 but the fault was only addressed in September 2017.

The upstairs hoist had been identified at the previous inspection as requiring repair but we saw this had still not been actioned. Whilst undertaking a walk round of the service, we noted there were no showers. There was a shower head to fit on taps hanging on the wall but when we looked at the connection it was not compatible with the bath or sink taps. We saw a large jug on the side of the bath and asked staff what it was used for. We were informed the jug was used to wash people down and their hair. This did not demonstrate a dignified and caring culture.

During the inspection, we observed people on the second floor shouting out but did not see staff respond. People were observed to spend long periods of time without staff engagement or interaction, and on some occasions staff missed opportunities to engage with people. For example, we observed people were sat in lounges and staff sat on the chairs at the back of the room chatting together. A visitor told us; "I feel people sometimes smell and should be supported to change more frequently. People ask me to take them to the toilet because staff are upstairs and not here to help them."

We observed when staff had time to spend with people this was not always used effectively. We observed a member of staff on two separate occasions standing in the lounge area looking out of the window. On both occasions, when they noticed us approach, they started engaging people in conversation. We saw this had been raised via the survey were it was documented; "As recommended by mental health care, staff to sit and

keep people company several times a day as a duty of care."

There was insufficient dining furniture and chairs to enable people to be accommodated in dining rooms and staff referred to meals as; 'teas on knees'.

This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities); dignity and respect.

We saw staff knocked on bedroom doors and identified themselves before entering people's bedrooms. The domestic staff member when cleaning communal rooms engaged people in conversation and we saw them ask people before cleaning the television. Staff told us how they promoted people's dignity; "We talk the person through everything we are doing, step by step and always maintain the person's privacy by making sure the person is covered up when providing personal care and doors and curtains are shut."

People we spoke with told us that their independence was, in general promoted and that they could receive visitors in private, should they wished to do so. They also told us that they were offered a variety of choices, such as where they would like to sit, what they wanted to do, what they wanted to wear, whether they wanted to be supported or not and what time they wished to get up. A person said; "They support me with walking. I'm getting stronger and once I'm walking again, I'll be going home." Staff told us; "Encouragement is given to people to maintain as much independence as possible. We always ask first. For example, a person may need support mobilising and walking to the toilet but they can toilet themselves so it is just accompanying to and from the toilet that I would support with." "People can tell you their needs and what they need support with but I always ask first and when supporting personal care, I encourage the person to wash themselves."

Requires Improvement

Is the service responsive?

Our findings

During the inspection we looked to see how people were engaged and provided social stimulation. A person told us; "There isn't something on every day so we tend to watch television. We had a party on Wednesday and we've had school choirs in." A second person said; "Staff don't push you to do anything. Staff help you to get up, get breakfast and then watch TV but half the people are asleep most of the time." A third person said; "No, I'm not happy with the activities. There are none available most of the time."

During our inspection visits, we didn't see any engagement with activities. People were sat in lounges watching television or remained in their bedrooms. We were told there was no activities coordinator so there was no structured programme of activities. We noted there had been entertainers in the home in November 2017 and school carol singers in December 2017. A visitor told us; "The staff sometimes does things with them. There is one staff member that reads with people. Nobody is ever taken out of here though. I've never known an outing to be arranged." A staff member said; "I feel there is enough going on for people if they want to do something."

We noted from the surveys conducted that responses had indicated there was insufficient activities and a person had highlighted they wanted to be taken out.

We saw visitors were able to come and go as they pleased so people's relationships were encouraged and maintained. However, we noted there were insufficient chairs for people living at the home and all the bedrooms we went in didn't have chairs which meant visitors would be required to sit on people's bed.

We looked at three care files to establish how people living at the home had their individual needs assessed. We could not find initial assessments about people's care and support needs in their records to demonstrate how care was planned and considered to determine whether people's needs could be met prior to them moving in to Oakwood Care Centre.

We noted 'my goals, aspirations and achievements' had been documented to indicate engagement with people to capture this information on commencement of their care at Oakwood Care Centre. For example; to maintain contact with family, remain independent, be asked about care, enjoy listening to music and helping staff. Care files also listed who was important to the person. Support plans included; physical and general health, diagnosis, mental health, medication, personal care, continence, toilet, nutritional needs, evening and night time routines. We noted some personalised information was captured pertaining to people's likes, for example on the personal care plan; details like whether the person liked deodorant and perfume were captured. However, this was not explored in detail to consider whether the person had a gender preference as to who supported their personal care and how frequent they would want their care needs to be met.

People's social history, culture, religious needs, hobbies, interests had not been captured or explored in detail to support planning. This meant the service could not be ensured people's individual care needs were being met. Care plans and reviews were also signed by staff which meant the service was not including

people in reviews of their on-going care or supporting people to express and document their views or preferences following admission.

The bathrooms only had a bath and there was no shower which meant people were unable to be provided a choice. A person told us; "They are hard work the baths. I'd rather a strip wash and my hair wash when the staff are available." A second person said; "I like my door open, I cannot be doing with it being closed. I don't like baths, I'm washed down and the hairdresser is very good." We spoke with one visitor who told us prior to moving in to the home their relative had always taken showers and was now limited to a body wash as they would not go in to the bath. We noted from the survey responses, comments included; "There are no shower facilities and I am unhappy with the condition of the lounge."

This was a breach of Regulation 9 of the Health and Social Care Act 2010 (Regulated Activities) Regulations 2014; person-centred care as the registered provider could not demonstrate care was designed in conjunction with people and met their needs.

We were informed of some examples of person centred care being provided. For example; a person at the home liked Heinz tomato soup so this was purchased for them and when people requested a chippy, staff accommodated this. We were also told people saw the hairdresser and chiropodist as they wanted which the provider paid for and was often not reimbursed by people's families. A person also told us they missed animals but the manager brought their dog in and that they loved seeing it.

We looked to see how the staff promoted equality, recognised diversity, and protected people's human rights. The home had a equality and diversity policy in place and management were positive about how people's needs would be met. We saw relationships were maintained and at the time of the inspection there was a couple sharing a room at the home. We saw one person had sensory needs as they were registered deaf. We observed a flashing door bell had been fitted to their door and observed the manager use some sign language and we were told the person could lip read so we saw the manager use animated words which the person responded to.

The service did not provide end of life care directly but we were told people could be supported to remain at the home by external professionals. At the time of the inspection nobody living at the service was in receipt of end of life care (EoL). We saw from care files that there had been attempts made to discuss people's end of life wishes with them.

Throughout the inspection we did not see the complaints process advertised around the home to ensure this was accessible to people or visitors so they were familiar of how to raise concerns.

We reviewed the home's complaints file and found a log of complaints was not maintained. We saw there were two emails in the file raising complaints. One email had been sent to the registered provider expressing concerns that there had only been two staff on duty at the weekend. The second complaint was in regards to the time a person had been supported to bed. We found there was no response to either complaint or outcome to determine actions taken. People we spoke to told us; "I've no complaints, nothing to complain about. All the staff are easy to talk to if I had a concern." "I've no complaints. I would tell the manager if I did." However, a visitor said; "I've complained about the smell and that the furnishings and carpets need replacing." There was no record in the complaints file to indicate this had been raised or addressed. We found the registered provider was not operating an effective system to respond to complaints as it could not be demonstrated where efforts had been made to analyse and act upon any complaints that had been made about the home to respond and drive improvements at the service.

This was a breach of Regulation 16 (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Receiving and acting on complaints.

We noted the service had also received five compliments. Compliments included; 'Thank you all for your kind care', 'Having an excellent manageress that leads by example helps, we cannot thank you enough for your kindness, care and hard work over the years', 'the manageress made me feels so welcome, I saw straight away this home had something that the others didn't and there was a plan to give it back it's sparkle. [My relative] has settled in well, the staff are lovely and their room smells fresh. There is still lots to be done cosmetically but I would still recommend the home.' 'Thank you to the cleaner for all their hard work, so lovely to smell flowers and not urine.'

Inadequate

Is the service well-led?

Our findings

At our first comprehensive inspection in January 2017 we found a lack of leadership and provider oversight of the home. Following this inspection, we took enforcement action and issued warning notices. The home was rated as inadequate and it was placed in special measures. At the time of our January 2017 inspection, the registered manager had only been in post for a few days but they had over 20 years managerial experience so it was felt they had the necessary competence and skills to make the necessary improvements.

At this inspection, we identified continued concerns with the leadership of the service and with the lack of improvements in response to the concerns we identified at the last comprehensive inspection in January 2017.

The expectation would be following the previous inspection and the 'inadequate' rating, the registered provider would have ensured the quality of care received had continued to improve and attained a rating of either 'Good' or 'Outstanding' at this inspection. This had not been the case as we found the registered provider had no oversight of the service and the registered provider had failed to meet the regulations in respect of; person-centred care, privacy and dignity, consent to care, safe care and treatment, governance and staffing. This meant the quality of the service provided to people living at the home was not continuously improving over time and as a result of the regulatory breaches found at this inspection, the service will remain in special measures.

We looked at the information we held on our system about the registered provider. The registered provider was the sole director and the only person with control over the company. The operation structure at the home had been the registered manager, deputy manager senior carer and care staff. As the registered manager had left, the deputy manager had stepped up to the manager role and was intending to register with CQC. The senior was acting up in the deputy manager position and one of the carers had been promoted to senior. On day one of the inspection we asked the registered manager what oversight the registered provider had given to ensure little disruption to the service whilst they were leaving. We were told they had not seen the registered provider for seven to eight weeks prior to them leaving.

We found the service was not well led. Throughout our inspection at Oakwood Care Centre, we identified a number of shortfalls in the way the service was managed. It was of concern that a number of serious risks to the health and safety of people living at Oakwood Care Centre had not been identified prior to our inspection and action was only taken as a result of us identifying the issues.

This is of particular concern given the history of non-compliance with the regulations. Following our previous inspection in January 2017, we found the registered provider had no oversight or governance to ensure the safe and effective running of the service. We met with the registered provider who assured us action would be taken and audits and governance systems would be implemented. In March 2017, the registered manager sent us an action plan stating all the required improvements had been completed.

The registered provider has a statutory duty to ensure systems are in place and operated effectively to ensure quality and safety. This includes assessing, monitoring and improving quality, safety and mitigating risks. The registered provider was unable to demonstrate oversight of the service which was a reoccurring theme identified from the last inspection. During the inspection, staff and the registered manager expressed a lack of confidence in the registered providers understanding of the regulations, issues being raised or urgency to resolve concerns.

During this inspection, we found the registered provider had still not undertaken audits to oversee the regulatory activity. We spoke to the registered provider on the last day of our inspection as they were on site at the nursing agency that was operated from the attic at Oakwood Care Centre. The registered provider acknowledged they were not doing audits or completing action plans but said they knew what was occurring at the service because they had received regular communication from the registered manager and manager by email. We also ascertained the registered provider had never attended care provider meetings.

We looked at the audits which had been undertaken since our last inspection. The only audits that had been completed were by the registered manager and included; seven care plan audits that had been completed between May 2017 and November 17. However, of the seven audits completed there were no details regarding the audit findings and actions taken. We saw the last weekly and monthly medicines audit conducted was September 2017. There was also a Health and safety quarterly audit that had last been completed September 2017. Following our second inspection visit and walk round with the manager, the manager had introduced a weekly room audit to ensure everything was working in people's bedrooms and included a check of; call bells and to determine there was no broken furniture.

Where audits had identified areas for improvement the registered provider had not ensured swift action was taken to address the issues. For example, an infection control self -audit tool completed as far back as October 2016 had identified the back lounge carpet and worn chairs needed replacing. We also saw dementia training had not been obtained which had been identified at our inspection in January 2017.

We found the culture of the home did not always question practice, and the leadership was not driving forward improvements. We looked to see how the registered provider sought the views and opinions of people who used the service and/or their representatives. For example, through the use of resident and relatives surveys or meetings. We saw surveys had been sent but there had been no analysis of the surveys completed. We noted reoccurring themes from the survey received; not enough chairs, telephones not being answered promptly, issues with the food and there not being enough trips. The manager and registered provider had no knowledge of the responses and were unable to demonstrate actions taken in response to the surveys received.

We saw the service had policies and procedures in place and looked at the business continuity plan but they referred to the previous regulations and had not been updated in line with legislative changes and current best practice.

Staff told us they felt they could have their say in team meetings and regarded them an open forum for discussion. We were told staff meetings were conducted regularly; however, we could not find the minutes of the meetings to corroborate this and the minutes seen had no actions identified during the meeting to enable us to track whether the registered manager had taken the required action or responded to issues raised.

The above failings demonstrate a continued failure by the provider to ensure regulatory requirements were being adhered to. This is a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated

Activities) Regulations 2014.

We asked staff, people using the service and visitors whether they felt the service was well-led. Staff told us; "I feel the management is good. I last saw the provider in May." "Both the registered manager and the manager have been good. I've been happy with both managers and that I could approach them." A person said; "The new manager is nice. I've known them a long time." A visitor told us; "The owner promises things but they're not delivered. The decoration plan didn't happen. I feel the management are hampered because of the owner. The home needs financial investment but owner doesn't want to spend the money. I feel let down with what was promised regarding the environment and hasn't happened."

The registered provider is required under the regulations to display the most recent inspection rating to ensure transparency and so that people and their relatives are aware of the quality of care provided at the home. We checked the providers' website prior to undertaking the inspection and the rating was not displayed. On arrival at Oakwood Care Centre on 14 December 2017, we asked to see the ratings displayed but these could not be found. This meant the provider had not adhered to legal requirements or been open and transparent with people using the service as to the quality of the service provided as the previous inadequate rating following the January 2017 inspection was not displayed. We are following this up outside the inspection process.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider could not demonstrate care was designed in conjunction with people and met their needs.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The provider had not ensured staff consistently treated people in a kind and compassionate way. When providing personal care reasonable steps had not been made to meet people's personal preferences.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider could not demonstrate they were assessing the risks to the health and safety of service users receiving care or treatment. The provider had not ensured the safety of the premises or assessing the risk of, and preventing the spread of infections. Medicines were not managed safely.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment

The provider did not have a central system to manage DoLS which had resulted in authorisations expiring and people being detained unlawfully.

There were no assessments and screening tools in place to determine if people were being deprived of their liberty to determine whether an application was required for a DoLS which could result in people being detained unlawfully.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints The provider could not demonstrate they had an effective system in place for receiving and acting upon complaints.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had not maintained oversight of the service

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider had not ensured complete employment checks prior to staff working at the home.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had not ensured the staff had the required support, competency, skills and training to undertake the role.