Majesticare (Oak Lodge) Limited

Oak Lodge Care Home

Inspection report

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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 undertook an unannounced inspection of Oak Lodge Care Home on 3 October 2017. When the service was last inspected in September 2016 we found three breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During the September 2016 inspection, we identified the provider was not doing all that was reasonably practicable to reduce identified risks to people and the provider had not ensured that people's medicines were always administered in line with their needs. In addition to this, we found there was not always sufficient staff to meet people's needs and governance systems to monitor the health, safety and welfare of people were not used effectively.

We set requirement actions in relation to the breaches of regulations we identified in September 2016. The provider wrote to us in December 2016 to tell us how they would achieve compliance with these requirements. During this inspection, we found that insufficient action had been taken to meet the requirements of the three regulations the service had breached at the inspection in September 2016. In addition to this, we found breaches in other regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Oak Lodge Care Home provides a service for people who require personal and nursing care. The service is able to accommodate up to 47 people. The building is divided into two parts. The main part provides nursing care to older people and The Acorns provides care for up to eight people who are living with dementia. At the time of the inspection there were 37 people living at the service.

There was no registered manager was in post at the time of inspection. The registered manager in post at the time of our previous inspection was no longer employed at the service. A new manager had commenced employment prior to this inspection in August 2017, but was not available on the day of the inspection due to annual leave. 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. In addition to this, the deputy manager in post at the previous inspection was no longer employed at the service. A new deputy had commenced employment approximately one week prior to our inspection.

The provider had failed to ensure sufficient improvements had been made in relation to the safe management of medicines. Current practice did not ensure people were fully protected against all risks associated with medicines. We found that where the service had identified risks to people, measures that could be taken to reduce these risks were not always in place or clear, exposing people to risk. We found that fire evacuation plans were unsafe, with the current record of people living at the service being inaccurate and no guidance for staff on how to escort people during an evacuation.

Accident and incidents were recorded, however no analysis was completed to identify patterns or trends to reduce any risks that may be present. We requested an analysis of historical incidents which were sent to us following the inspection, however these records were dated after the inspection so had been produced retrospectively at our request. People gave mixed feedback on staffing, however from examples we were given it was evident the provider had not taken sufficient action since our last inspection to ensure that sufficient staff were consistently deployed to meet people's needs.

The service had not met their responsibilities with regard to the Deprivation of Liberty Safeguards (DoLS). DoLS is a framework to approve the deprivation of liberty for a person when they lack the mental capacity to consent to treatment or care and need protecting from harm. 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 Mental Capacity Act 2005. At the time of the inspection there was no system to monitor current applications and DoLS status so it was unclear who had a DoLS application in process.

The service had not complied with the principles and legislation set out within the Mental Capacity Act 2005. Consent to care was not consistently sought in line with current legislation and guidance and best interest decision records or meetings had not been completed when required. There was currently no effective system in operation that monitored training provision and staff feedback was mixed about the style and platform training was currently being delivered. Some staff had not received an induction in line with the provider's policy and their competency had not been assessed in certain aspects as a result of this. Staff supervision and appraisal evidencing staff were well supported in their role had not been completed as required. Improvements were needed in relation to the monitoring of people's food and drink intake and a more person centred approach to some people's dining experience was needed.

Although people's feedback was positive, we found the service was not fully caring as poor staffing levels had resulted in people's care needs not being consistently met and their dignity being compromised. Some people reported how they had waited a significant amount of time to use the toilet and another person explained they had purchased incontinence pads due to the significant time it could take staff to support them to use the toilet. We made observations of people waiting for the toilet and this matter was also raised as a concern during a recent relatives meeting.

The quality and detail of people's care plans was inconsistent. People and their relatives had commented that they did not feel involved in reviews and some reviews were overdue. Within some people's care plans we found key information about people, their preferences and things that were important to them had not been completed. This would help to ensure care was delivered in a person centred way. We found that people's end of life care plans were incomplete and required improvement.

People gave examples of when care was not delivered in line with the needs and preferences. For example, some people told us they were left in bed for too long during the day and others told of how they continued to be supported by care staff of the opposite sex despite raising this with the service. The complaints system in operation required improvements to ensure people's complaints and concerns were addressed consistently.

The provider had failed to ensure that sufficient governance systems had been implemented to monitor the health, safety and welfare of people. Ineffective governance had not identified the concerns we found during our inspection and placed people at risk. The service had received provider level governance checks and auditing that had identified concerns, however a second or follow up audit had not been undertaken to monitor if the shortfalls previously identified had been addressed. The provider had failed to ensure their rating was displayed as required by law and people were unsure of the current management arrangements.

The environment was maintained and equipment used within it was subject to regular testing and servicing. There were safe recruitment procedures in operation and staff understood how to identify and report suspected abuse. People felt safe and told us they received effective care and we found people had access to healthcare professionals when needed. We observed positive interactions between people and staff and people said staff were caring. Staff understood the needs of the people they cared for and visitors were welcomed. People had access to activities within the service. Staff we spoke with were positive about the new management and future direction of the service.

We found three continuing breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and identified a further four breaches. We are considering the action we are taking and will produce a further report.

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.

Medicines management was unsafe placing people a risk.

Risks to people were not always identified or mitigated.

There were insufficient staff to meet people's needs.

Fire evacuation planning did not fully protect people from harm.

Accidents and incidents were not analysed to reduce risks.

Is the service effective?

Requires Improvement

The service was not fully effective.

Deprivation of Liberty Safeguards applications were not monitored.

Mental Capacity Act 2005 practice did not protect people's rights.

Staff training, induction and supervision was not effective.

Improvements were needed in relation to monitoring food and drink intake.

People had access to healthcare professionals.

Is the service caring?

Requires Improvement

The service was not consistently caring.

Insufficient staffing levels did not ensure people always received good care.

People's care did not consistently ensure their dignity was maintained.

People's spoke positively of the staff that supported them.

We made positive observations of staff and people interacting.

People's visitors were welcomed at the service.

Is the service responsive?

Requires Improvement

The service was not fully responsive.

Care records were not consistently detailed or person centred.

Reviews did not always involve people or their representatives.

Care was sometimes otherwise in accordance with people's preferences.

Improvements were needed in the management of complaints.

People could be involved in activities at the service.

Is the service well-led?

Inadequate

The service was not well led.

Governance systems were not effective in reducing risk.

Auditing systems were not monitored or consistently completed.

The provider had not displayed their rating as required.

People were unsure of current management arrangements.

Staff were positive about the future of the service.

Oak Lodge 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.

This inspection was carried out by two inspectors, an inspection manager and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. When the service was last inspected in September 2016 we found three breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Before the inspection the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, tell us what the service does well and the improvements they planned to make. We also reviewed the information that we had about the service including safeguarding records, complaints, whistleblowing information and statutory notifications. Notifications are information about specific important events the service is legally required to send to us.

Some people in the service were living with dementia and were not able to tell us about their experiences. We used a number of different methods such as undertaking observations to help us understand people's experiences. We spoke with 19 people who used the service and six people's relatives or visitors. We also spoke with 11 members of staff. This included the provider's clinical and governance lead, the deputy manager, nursing staff and care staff.

During the inspection, we looked at 10 people's care and support records. We also reviewed records associated with people's care provision such as medicine records and daily care records relating to food and fluid consumption. We reviewed records relating to the management of the service such as the staffing rotas, policies, incident and accident records, recruitment and training records, meeting minutes and audit reports.

Inadequate

Is the service safe?

Our findings

At our inspection in September 2016, we identified that the provider was not doing all that was reasonably practicable to reduce identified risks to people and the provider had not ensured that people's medicines were always administered in line with their needs. In addition to this, we found there was not always sufficient staff on duty to meet people's needs. The provider wrote to us in December 2016 to tell us how they would achieve compliance with these regulations. During this inspection, we found that insufficient action had been taken and the service remained in breach of the regulations.

Medicine administration was still unsafe and placed people at risk. We looked at all of the current Medicine Administration Records (MAR) in the main area of the service and saw there were 12 gaps where staff had not signed to confirm people had received their prescribed medicines. This meant there was a risk that people had not always received their medicines as prescribed. There was a system in place to monitor the MAR at the end of each shift to ensure it was accurate, but this was not consistently followed by staff because staff had not always signed the check sheet. Because these checks had not always been completed, it was not clear if staff had identified the omission of signatures or whether they had checked that people had received their medicines. This did not evidence medicine administration was safe.

Some people had not received their medicines because staff had documented they were out of stock. The lack of stock management control meant there was a risk that people would not have their medicines as prescribed. For example, one person was prescribed pain relief which had been out of stock for 24 hours. Another person's medicines had been out of stock for two days and another person's pain relief medicine had previously been out of stock for four days. The latest pharmacist advice visit dated 12/04/2017 made a recommendation for the service to, "Make sure there is stock available for all residents." This demonstrated these stock problems were apparent approximately six months before our inspection and insufficient systems had been implemented to address the issue.

Although staff had documented when medicines were out of stock, other reasons for not administering medicines had not been consistently documented on the MAR. By documenting the reasons for non-administration of medicines, staff would be able to identify any issues or trends that may require escalating to the person's GP for them to conduct a review. This issue had been highlighted during provider audits in August 2017, but was still not resolved and there was no supporting evidence any action had been taken to address the identified concerns.

We observed a member of staff administering medicines to one person on a medicines round. This was done safely and the staff member asked the person if they were happy to take their medicine. They ensured they had swallowed it before signing the MAR and took their time. However, we did see that another person still had medicine on their table during the afternoon that had been given to them in the morning. This evidenced that staff did not always check people had taken their medicines before signing to say they had been taken as prescribed placing people at risk.

Most of the MAR we reviewed had photographs of people at the front. These were dated, but some were 18

months old and so might not be a true likeness of people anymore and could lead to identification issues during a medicines round. This is particularly relevant when staff who are not familiar with people are administering medicines, such as agency staff or new staff. We did find one person's MAR did not have any photo on the front that again presented a risk of misidentification during a medicine round by unfamiliar staff. Allergies were documented, but people's preferences in relation to how they liked to take their medicines had not been consistently documented.

Pain relief patch records were not used consistently, because some were completed every time a patch was changed and some were not. This meant it could be difficult for staff to ensure they rotated patch positions in accordance with manufacturer guidance, placing people at risk. Some people were prescribed PRN (as required) medicines, for example paracetamol or ibuprofen. PRN protocols provide information to staff on when and why people might require these additional medicines, such as for pain relief. They are particularly useful for informing staff how people who are unable to communicate might show signs of pain. Additionally, the protocols detail key information such as how to administer these medicines and maximum daily doses permitted. We found there were no PRN protocols in place for any person, placing them at risk.

Medicines were not always stored safely. The temperatures of the clinic room and the medications room were monitored daily. However, records showed that the temperature in the medication room had exceeded the maximum recommended temperature on six occasions in August 2017 and on seven occasions during September 2017. There was nothing documented to indicate that staff had recognised the temperature was too high, and nothing documented to indicate if this had been reported or if any action had been taken to reduce the temperature. Medicines stored above their recommended storage temperature may become less effective or unsafe to administer.

Medicines that required additional storage measures were stored safely and were checked on a daily basis. However, it was not clear if discrepancies were always reported. For example, there was a discrepancy noted with the remaining volume of one bottle of medicine on 26/09/2017, but there was nothing documented to indicate that this had been reported as a medicines incident. This meant that although the medicines stock discrepancy had been identified, it had not been escalated and an investigation completed to establish the nature and circumstances of the discrepancy.

On the whole, people were happy with the way their medicines were managed. However, we did receive some less positive comments. One person told us, "You never know what time they are coming - you want them regular." One person was very critical and told us, "They don't follow the rules. They have done the last few days. But it's not always the same routine. I know my meds as I have had this [the illness] the last 17 years. Either they've not been given the rules or they've not listened. On one occasion I had no water and they took the toothbrush out of the mug and gave me the water the brush had been in. Two new one's [staff] just give me the pills and leave." Another person told us, "I take a lot of tablets. One night they missed my tablets. Another night they missed and a worker woke me at 2.30am to give them to me."

Records of topical administration of creams and lotions were in place but these were not consistently signed by staff. For example, one person had been prescribed a cream to be applied, "During every intervention", but the record had not been signed every day. Since 09/08/2017 the chart had only been signed by staff on 21 occasions which meant that on 34 days the person did not have the cream applied or a supporting record had been accurately completed to evidence the cream had been applied. Another person was prescribed a daily cream which had only been signed for eight times since 26/06/2017. Additionally, instructions for staff were vague because there were no body maps in place to show exactly where creams and lotions should be applied and how frequently. The guidance for staff on how and when to apply the creams was recorded as, "As required" and gave no further detail. This meant there was a risk that

people would not always have these items applied as prescribed.

Care plans contained risk assessments for areas such as mobility, moving and handling and falls. These had been reviewed, but not always on a monthly basis. When risks were identified, the plans provided some detail for staff on how to reduce the risks for people, but the information was sometimes limited. For example, moving and handling plans did not always specify which size sling staff needed to use if hoisting was required. One person had been assessed as at high risk of falling, but guidance for staff was, "A high risk of falls due to dizziness and for this reason has a sensor mat in place" and there was no other detail in place which did not evidence clear risk management guidance.

Where risks to people had been identified, steps to reduce or mitigate these risks had not always been completed placing people at risk of unsafe care. For example, one person had newly arrived at the service following a hospital discharge six days before our inspection. Within the information supplied from the local authority, it was highlighted to the service the person was at risk of skin breakdown due to continence issues. In addition to this, at the point of discharge from the hospital the person was rated at 'Very high risk' of skin breakdown or damage using a nationally recognised tool. Despite this information being provided to the service, no risk assessment had been completed by the service in relation to the person's pressure ulcer risk. In addition to this, no plan of care detailing how the service would manage the risks was created. This placed the person at risk of pressure ulcer development.

Although wound care plans contained photographs of people's wounds and the dressing plans were clear, we found when people had been assessed as being at risk of pressure sores, the plans did not always contain clear guidance for staff on how to reduce the risks. For example, position change guidance was often documented as, "Regularly" rather than specifying the exact frequency, although sometimes the frequency was written in the person's sleep plan. Position change charts did not reflect that people had their positions changed regularly, because they had not always been completed by staff. We looked at the charts for 02/10/2017 for three people who had been assessed as being a very high risk of developing pressure sores. One of these already had sore areas. The position charts for all of these people did not demonstrate that people had their positions changed regularly. The chart for one person showed they had been assisted to sit up in bed at 09.00am and then moved to their right side at 10.30am, but there was nothing documented for the rest of the day. The other two charts had also not been completed accurately throughout the day.

Other care record we reviewed did not always contain details on how to meet people's specific medical needs. For example, one person was an insulin controlled diabetic but there was no diabetes plan in place. This did not evidence the service followed published national guidance in relation to diabetes by creating a person centred care plan on the management of the condition. This meant it was not clear how staff would know how to meet the person's needs or how to support them if they were unwell. Within another care record, a person had been assessed as at high risk of choking. Although the signs of choking had been listed within the person's records for staff, the required action for staff to take in the event of a choking episode was not. This meant there was a risk staff may not know what actions to take should the person require urgent support when choking.

Emergency arrangements for actions to be taken in the event of a fire or other emergency situation placed people at risk. People had evacuation assessments in place in case of an emergency. However, these were not easily accessible and were held within the large files of care records. In addition, they lacked any information about people's cognitive and behavioural needs that would need to be taken into account should they need to be evacuated from the service. Furthermore, there was no guidance that showed the level of support people required to evacuate or the method in which they would leave the building. We

reviewed the fire folder handed to us by the senior management on duty. This information form that stated who was currently living at the service showed it was last updated in May 2017. It contained inaccurate information about who was currently living at the service. For example, one person's name appeared twice and another person who had recently moved to the service was not recorded.

The absence of a regular accident and incident analysis did not fully protect people from the risk of avoidable harm. There was evidence in people's records and in a main file, held centrally, that accident forms were completed for people. There was some evidence that action was taken by care staff in response to falls, for example by using sensor mats to alert staff if people were moving around in their room. However, there was no overall management level analysis of accidents and incidents to identify risks, themes and trends to inform action to mitigate future risk. We identified this shortfall to the senior manager on duty who stated a record was within the central file. We requested this be sent to us as part of the inspection. The information sent to us was the accident and incident analysis for July, August and September 2017. These analysis records were dated as being completed after the inspection showing an analysis had not been completed at the time.

This was a continued breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the previous inspection we found that insufficient staff had been deployed to consistently meet the needs of the people at the service. In the 3 month period prior to our inspection, we were contacted by different staff who wished to report to us that staffing levels were unsafe and people were not receiving the care they needed. We spoke with a senior member of the provider's staff in July 2017 and a full dependency assessment of people's needs was undertaken. The provider engaged with staff about the current staffing levels. Despite this intervention, people living at the service gave us examples of their experiences where continued insufficient staffing meant their needs were not consistently met.

On arrival at the inspection, the newly employed deputy manager did not know the current occupancy numbers of the service or the staffing arrangements due to only having been employed for four shifts prior to our visit. They were also the nurse in charge of the service and responsible for the people and staff. The newly employed manager was on annual leave and had been the previous week when the deputy manager started employment. This did not demonstrate that effective measures had been put in place by the provider to ensure that staffing numbers met people's needs and the deputy manager was supported from the commencement of their employment.

Staff we spoke with also gave mixed views of the staffing levels. Some staff we spoke with told us they felt there was sufficient staff on duty to meet people's needs, however others commented negatively. For example, some staff said they felt there was not enough staff on duty to meet people's needs. Positive comments from staff included, "None of the care staff have said to me that they're short staffed" and, "Staffing is ok. The new manager won't run the home short staffed. She'd rather have too many staff than not enough. Personal care is done before lunch now, which it wasn't before." Despite this, we saw that people did have to wait for assistance. We observed one person asked to go to the toilet. A member of staff said they would get someone to help them and then returned and said to the person, "They're [other staff member needed to support the person needing the toilet] just in the middle of getting somebody up." The person waited 15 minutes for staff to come and assist them. We observed that at 11.30am 15 people were in bed, however when we asked staff about this, they said it was people's choice to stay in bed.

Other staff told us that the main part of the service was often short staffed and this meant they needed to get a member of staff from the Acorns unit to support their staff team in the main area, leaving one member

of staff to assist people in Acorns. A relative spoken with told us that staff seemed, "Overstretched" especially in the main building with call bells ringing for long periods. They told us that they had visited recently and had to find staff for a person [unrelated to them] who they felt was calling out and in pain. They told us it took, "Quite some time for staff to come." One person told us that there was, "Not enough staff upstairs [the main area of the home], better in Acorns." They told us they felt they only had 10 minutes to be helped to get dressed in the morning and to go to bed in the evening. They felt they were rushed and needed 20 minutes each time for this help. Although the service did not have specified times to assist people with personal care, this person felt they needed longer with their support indicating they felt the care they received was hurried.

Other people we spoke with gave their experiences of staff within the service. They commented on the staffing levels and the continuity of staff. One person said, "They're so understaffed. They're lovely, but working themselves to a standstill. Agency are no good." This person said that they used to have the same staff but that now this was not the case. However, they did also say that there were also helpful staff. They told us, "It's a lovely place really and staff are so helpful. They are just overworked. They need more help. It's especially bad at night. They're overworked. That's the whole trouble." Another person commented on their current concerns with staffing and the fact that people do not always have the same staff. They said, "A few I feel I know but some I don't know as well."

Some people felt their needs were not always met by the staff. One person told us that they would press the bell when they wanted to go to the toilet and when staff arrived they would say, "What do you want - You've only just been." This person explained that sometimes they needed to go to the toilet more. Another person said their needs used to be met but, "Now I have to put up with it." However, others where happier about their needs being met. One person said, "They've always been all right with me." Another person told us that they always had a quick response to their bell as they were on, "Urgent."

We received other negative information about people having to wait for excessive periods of time for basic care needs. One person told us that although it only happened on one isolated occasion, they had to wait for two hours when they needed to go to the toilet. They recalled how this had made them uncomfortable and they were worried about moving or sneezing as this would result in them urinating themselves. Another person commented on how consistently waiting for staff had resulted in them having to purchase continence products to use in case they urinated themselves due to slow staff response times.

Although the feedback we received was mixed, it was evident that people's care and treatment needs were not always consistently met due to insufficient staffing numbers. We saw through reviewing relatives meeting minutes that several relatives had raised staffing level concerns at a meeting held in August 2017.

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

The environment and equipment used within the service was maintained to ensure it was safe. The provider had dedicated staff at the service that monitored all aspects of the environment and the equipment. We reviewed information that detailed the regular maintenance and servicing of mobility equipment undertaken. Environmental aspects such as the fire alarm, fire extinguishers and emergency lighting were tested. Records showed that there were also systems that ensured the nurse call bell, gas appliances and portable appliances were serviced and checked. Mobility equipment used within the service, for example hoists, was also serviced. Equipment such as weighing scales also underwent a programme of recalibration.

Safe recruitment processes were completed. Staff had completed an application form prior to their

employment and provided information about their employment history. Previous employment or character references had been obtained by the service together with proof of the person's identity for an enhanced Disclosure and Barring Service [DBS] check to be completed. This DBS check ensures that people barred from working with certain groups such as vulnerable adults are identified. In addition, the service had ensured that where necessary a staff member's registration with the relevant body was current. This included nursing staff being correctly registered with the Nursing and Midwifery Council.

Staff knew how to recognise abuse and how to report allegations and incidents of alleged abuse. Policies and procedures were available to everyone who used the service. The staff we spoke with recognised their responsibilities and duty of care to raise safeguarding concerns when they suspected an incident or event that may constitute abuse. Agencies they notified included the local authority, the Care Quality Commission and the Police. Staff spoken with confirmed they felt confident action would be taken if they reported any concerns to ensure people were protected.

Requires Improvement

Is the service effective?

Our findings

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 application procedures for this in care services is called the Deprivation of Liberty Safeguards (DoLS). We checked whether the home was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met.

The provider had not met their legal responsibilities in relation to the DoLS. The senior manager present at the inspection confirmed that the tracker used by each home run by the provider had not been completed as required. As a result, no reliable record could be found of whether DoLS applications had been made or authorised. Care records we reviewed showed that DoLS application forms had been completed, but it could not be confirmed if these had been submitted to the local authority. No continuity of DoLS applications had been maintained or monitored effectively during recent management changes which had resulted in this important information being lost.

One record contained an urgent DoLS authorisation that expired on 22 February 2017. There was no extension authorised and no evidence that a standard authorisation had been applied for. The records indicated that the person's circumstances had not changed. Another person had recorded on 23/05/2017, "For [person's name] to have a DoLS in place." There was no evidence that a DoLS had been applied for. This did not demonstrate an understanding of the DoLS requirements which meant there was a risk that people at the service may be being unlawfully deprived of their liberty and that any conditions set on authorised DoLS were not being met.

This was a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

Consent to care and treatment was not consistently sought in line with current legislation and guidance. Although mental capacity assessments had been carried out for some aspects of people's care, they had not been carried out for all aspects of care. For example, several people had bed rails in place which are restrictive, but people's capacity to consent to the use of these had not been assessed. We looked at the care plan for one person with bed rails. It had been documented that the person lacked capacity, but in the bed rails assessment form staff had documented that the decision to use bed rails had been discussed with the person. Staff had written, "Yes, it has been explained and for safety reasons in [person's name] best interests." The form had been signed by a staff member but not by the person, evidencing consent had been sought. There was no record of any best interest decision meeting being held in relation to the use of bed

rails and there was nothing documented to show that staff had considered the use of any less restrictive means to keep the person safe. Similar documentation was seen in the plans of other people with bed rails.

We found other examples of where MCA principles had not been followed. For example, we reviewed a care record for one person with a sensor mat in place. Although a capacity assessment had been completed for, "Short term memory loss affecting the ability to maintain safe environment", there was no reference made to the use of a sensor mat and no evidence of any best interest decision meeting. The use of a sensor mat, although primarily in situ for the person's safety, is a restrictive practice monitoring people's movement. In addition to this, we reviewed the care records of a person who had moved into the service shortly before our inspection. The records showed the staff had recorded the person as having, "No capacity" during the pre-admission assessment completed. On attending the person's room, we saw the person was in bed and that bed rails were in use. In addition to this, there was a sensor mat on the floor that staff confirmed was in use. No capacity assessments or best interest documentation had been completed or undertaken in relation to the use of this equipment.

Within the Acorns unit, the care records had a system to support the process of MCA capacity assessments and best interest decisions. However, there was no record of any consultation with relevant persons and all consent records were signed off by one member of staff. The majority of records had not been fully completed, for example records did not show if other possibly less restrictive options to support people had been considered. For example, the use of sensor mats where three people in Acorns who had these in use. Although they were referred to in the care plan, there was no evidence that a best interest process had been followed as set out in the MCA Code of Practice. Night checks consent forms were completed inconsistently with one form recording evidence of consultation and agreement with the relevant person and others signed by a member of staff with no evidence of consultation.

Where people had records indicating their current resuscitation status, we found these were easily accessible. However, some of these forms contradicted the MCA assessments held on file for people. For example, in one file we reviewed it evidenced the relevant GP had recorded that the person had the capacity to make this decision. However, these people had been assessed by the service as lacking capacity. One form did not have any box ticked to confirm if the person had capacity or not to make this decision.

This was a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Improvements were needed in relation to the delivery and monitoring of training. Following our inspection we received the current training record for all staff at the service. During our inspection we spoke with staff and received mixed feedback on the current training provision. Staff gave mixed feedback about current training delivery arrangements. Training was primarily being provided through an online platform and staff completed the training at home or on organised training days within the service. When initially requested, we were told the staff training record was not current and required updating. We received the updated training record two days after the inspection. This did not indicate the service had a robust system to monitor staff training and its completion to ensure staff provided effective care.

The staff training record did not evidence that staff training had been completed as required. Key training elements were shown as, 'Module incomplete' which placed people at risk by staff not being trained in current practice or legislation. Furthermore, there was a risk that some staff may not fully understand the needs or conditions or the people they supported. For example, there were 61 staff listed on the staff training record. Of these staff, 17 were listed as either clerical, domestic, maintenance of kitchen staff. These staff however may also come into contact with people during the course of their duty.

On reviewing the training record, it evidenced that only 17 of the total staff had completed training in dementia. In addition to this, only 17 staff were shown to have completed training in the understanding of the Mental Capacity Act 2005. This is a key training element in a service working with people who have dementia or other cognitive impairment to ensure their rights are upheld and protected. When reviewing training in relation to the Deprivation of Liberty Safeguards (DoLS), this showed that only six staff in total had received training in this. The record further highlighted that two of these staff were recorded as, 'Kitchen staff' meaning only four members of either nursing or care staff had completed this training.

This training shortfall was reiterated when speaking with staff as some staff we spoke with did not have an understanding of the MCA or DoLS and some staff told us they had not completed the required on-line training. Further areas that required improvement in relation to training was that only a third of all listed staff were recorded as having completed training in safeguarding vulnerable adults and only five staff were recorded as having received training in whistleblowing.

New staff had not consistently received an induction in accordance with the provider's policy, and competency in key areas had not been assessed. For example, one staff member we spoke with was new in post and said they only had one day shadowing another member of staff. They had not undertaken any formal training or competency assessments as part of their induction prior to working unsupervised. This placed people at risk of receiving care from untrained staff. However, they did say they were booked in for manual handling refresher training the following week. The new deputy manager commenced employment about one week prior to our inspection and had worked four shifts. The deputy manager was shown on the rota as shadowing an agency nurse on their first day of employment and had not received an induction. In addition to this, the new deputy manager had been administering medicines since commencing employment without the service ensuring their competence through an assessment.

There was no effective method being used to monitor staff supervision or appraisal. The most senior manager in charge explained that supervision and appraisal had not been monitored in recent times. This was reflected through speaking with staff and when reviewing the record that showed what supervision or appraisals had been completed. On reviewing the record, it showed that only 11 supervisions had been completed in 2017. With no entries showing for January, June and July 2017. Some staff we spoke with told us they were unable to recall when their last supervision was. One staff member told us, "I can't remember" when we asked when their last supervision was and another said, "I haven't had one for at least six months." This did not evidence staff received the maximum level support when performing their roles.

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

Improvements were needed in relation to the monitoring of people's nutrition and hydration needs. We found inconsistent approaches within the service between the Acorns unit and the main part of the service. Within the Acorns unit, food and fluid charts were completed and total fluid intakes were recorded to enable this to be monitored. We checked some of these charts against the targets in the care plans and they showed people were receiving the fluids planned for. People were weighed regularly and one person who had been losing weight had now gained weight having been referred to the relevant professionals.

However, within the main larger part of the service we found improvements were needed. People were assessed for the risk of malnutrition. When required, specialist advice and support was sought. Records showed that people had been assessed by the Speech and Language Therapist (SALT) when required and care plans contained their recommendations. We saw that when people needed to have textured diets or thickened fluids this guidance was on a chart in people's rooms. When people needed assistance to eat, the

plan detailed this. In one person's plan, staff were guided to use a teaspoon to assist them with a pureed diet and we saw that this happened. People's weights were monitored.

Records showed that some people were having their food and fluid intake monitored. Although charts had been completed, fluid charts did not have daily targets written on them and care plans did not always specify how much people needed to drink. For example, in one person's plan it was documented that staff should, "Encourage fluids." The fluid chart for this person showed the person's fluid intake on 02/10/2017 was only 575 mls, but there was nothing to show that staff had noted or escalated the poor intake. However, in another person's plan the daily target had been documented as one litre per day and the fluid charts showed that the person had received 1100 mls the day prior to our inspection.

We sat with people at lunchtime and all said they enjoyed their meal, all were offered a choice and were happy with their choices. People had no complaints about the food and the people we sat with identified Sunday lunch as always being excellent. One person who had a pureed food diet had it well presented and it was clear to see what it was. They told us that it tasted as it should. However, due to an existing medical condition they found it difficult to eat using a teaspoon. They explained to us that it was easier for them to eat in hospital when they had adapted cutlery but that this was not available at Oak Lodge. We highlighted this to the senior manager on duty.

Interactions over lunch period were generally positive, however we did see some less positive experiences for people. We observed people being supported to eat their meal in the dining room and in their own rooms. In the dining room, we observed that support was not consistently person-centred as on one occasion a staff member was standing up whilst supporting them and there was no interaction with the person. We also observed this lack of person-centred practice for people being supported to eat in their own rooms. However, we also observed instances of positive practice in people's own rooms where the members of staff were sitting down by the bed, talking with the person during their lunch.

People generally felt that staff were knowledgeable when providing care, although some people clearly indicated they felt there was room for improvement. One person we spoke with commented, "They are quite knowledgeable. Some of them you have to tell them what to do." Another person said, "Half and half. Some are good and some aren't so good." One person said, "I've got to tell them what to do - what I want and what I want them to do. I get fed up with it." Positive comments described staff as being, "Very good." One person told us, "I'm extremely well looked after. No complaints at all."

People had access to healthcare professionals as required. From records we reviewed it showed the service maintained links with other healthcare professionals to ensure people's ongoing health needs were met. For example, records showed that when needed, people had been seen and reviewed by their GP, a Speech and Language Therapist (SALT) and the physiotherapist. The service kept additional records of when people had been visited by the chiropodist. An example of good practice was seen in the care record of a person who had recently been admitted to hospital. The person's records showed that staff had monitored this person as they had become unwell and informed the GP and other services appropriately.

Requires Improvement

Is the service caring?

Our findings

The feedback about the staff we received indicated they were caring towards people. Nobody living in the service or their relatives and visitors made any statements to us that suggested they thought staff were not caring. Positive comments we received illustrated that people felt staff wanted to their best for them. Despite this, during conversations with people, their relatives and visitors, we obtained evidence that indicated the service were not fully caring. The examples we were told of and read within meeting minutes showed that at times, people's dignity had been compromised through insufficient staff.

Some people were critical of the amount of time it could take for staff to respond to their care needs, particularly at night. One person, who told us on one occasion waited for two hours when they wanted to use the bedpan said, "I don't want to wet the bed. If I sneezed or anything I would. They say they're helping someone else but two hours is too long." While understanding that other people needed support, this person did not feel that they should need to wait so long. This compromised the person's dignity whilst also leaving them in discomfort for a significant period of time.

Another person we spoke with told us that they had to wait 30 minutes after ringing their bell at least once a week. This person told us they chose to buy their own continence aids because of the fact that they could not always wait that long and did not want to have an accident. This showed how the absence of staff did not ensure the person's dignity.

During our observations, we observed how people's dignity could be compromised. For example, we were with one person in their bedroom who complained that their stomach was hurting and said they wanted to use the toilet. A member of staff, who was not care staff, went to find appropriate staff to help but it was 15 minutes before anyone arrived. They were apologetic and explained that they had been helping another person. Following this delay, the person required hoisting before being able to taken to the toilet. During a conversation with another person they had nothing but praise for the service and the staff. They told us they never waited and pressed their bell to show how quick a response they got. The person called out then pressed their bell. After some time a member of the domestic staff arrived but did not turn off the call bell. Ten minutes later a nurse came to find out what they wanted.

Other examples of where poor staffing had resulted in people receiving less positive care that compromised their dignity was evidenced in meeting minutes with people's relatives. We reviewed the meeting minutes of a relatives meeting held in August 2017. This showed that relatives had raised concerns about staffing and the impact it was having on people in the service. For example, within the meeting minutes relatives had commented about people having to wait for care, with three relatives giving examples of where the delay in care had resulted in the person living at the service having an accident and soiling themselves.

This was a breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We observed positive interactions between people and staff. We saw that staff interacted well with people.

There was a pleasant atmosphere and people responded well to staff. We saw that staff asked people for consent before assisting them and told them exactly what they were doing. We observed staff talking with people in the lounge, in their own rooms and in the dining room in a kind and thoughtful way. We observed two staff chatting to one person who told us that, "They are quite nice, the staff." This person liked to sit with their door open so that they could sit in their chair and see who was passing. Staff had ensured that their chair was placed to enable them to do this. While we were sitting with this person, a number of care staff and domestic staff passed and all said hello and waved as they passed.

Another person we spoke with told us, "They are always pleasant and nice. My treatment is very good. They are respectful and they interact with me as they know I'm quite young to be here and my mind is alert. They give me ordinary interaction. It stops me going into the abyss of apathy." We observed two staff taking a person in a wheelchair from their room to the lounge and asking them, "Which room do you fancy today [person's name]. Do you want to look out of the window?" This showed people were given choices surrounding their care and social time. Although we have highlighted less positive information above, some people told us that their privacy and dignity was respected and that they felt individual staff were caring. One person said, "They try to make me laugh, they are very good they wait on you hand and foot. I don't know how they could improve to be honest."

During conversations with staff, it was evident staff knew people's needs well and could describe these to us. For example, staff explained how one person's catheter was managed, we were told about another person who could not manage tablets so was now able to have liquid medicine and also the specific diets that people required. This showed that staff aimed to deliver care unique to that person. Staff told us how they felt people received good care. For example, one staff member we spoke with said, "This is a really caring home, with dedicated staff." During a conversation with another member of staff they told us, "The level of care here is very good."

People could be visited by their friends and relatives at any time of day. There were no restrictions on people's relatives or friends visiting the service and relatives were welcomed. This meant that people living in the service were not isolated from those closest to them. During our inspection, several visitors came to the service to see people and there was a busy social atmosphere in the communal areas and people's bedrooms. It was clear that staff knew the visitors well when we heard them speaking with them. Relatives we spoke with were all very positive about the way they were treated and felt comfortable visiting at any time of the day. One person who stayed in bed in his room told us that his dog visited regularly when his family visited.

Requires Improvement

Is the service responsive?

Our findings

The quality and detail within people's care plans was inconsistent. It was not easy to understand people's needs due to the layout of the plans and the level of detail was poor. The care plans were not consistently person centred, although we did see some examples of where people's preferences had been included. For example, in one person's plan the person's clothing preferences had been included along with their preferred times for getting up and going to bed. However, we did not see this in the majority of the plans we looked at. Although some plans had pen portraits of people, these were minimal and did not give staff much detail about people's lives prior to living at the service.

Guidance was not consistently person centred and did not evidence how staff should meet people's individual needs. For example, one person's plan in relation to the behaviours they exhibited was very person centred and included details of triggers, distraction techniques and how staff should react to the person. However, in another person's plan it had been documented that when the person was confused or anxious they might throw objects at staff. In response to this, the guidance for staff was limited to, "Support her to express her needs" and, "Offer reassurance and empathy." There was nothing to inform staff how to de-escalate the situation or how to keep them or the person safe.

Within the Acorns unit, suitable recording and plans were not always in place for one person who could become distressed and spent long periods banging their hands on objects. Staff had been advised to complete an "ABC chart" to record this person's behaviour. This was completed inconsistently and there was no guidance in place for staff to follow in relation to recording, reviewing and taking action based on this monitoring. This meant that suitable action would not be taken to address this person's needs to help them to remain calm and suitably supported.

One person's care record did not demonstrate a consistent person centred approach to care. The person had been newly admitted to the service from hospital six days before our inspection. We saw that a pre-admission assessment had been completed, however it was not evident that any steps had been taken to personalise the care given to the person. We observed and heard this person often calling out at people and staff during the course of our inspection. When reviewing the person's records, we saw that information had been supplied to the service about the person from the local authority. General information was also included on a hospital discharge summary.

Despite this information being communicated to the service, key sections of the person's care plan were blank. For example, key person centred documentation that would support staff in understanding the needs and history of the person had not been completed. One document was entitled, "Important to me" and was blank. Other documents named, "My background, skills and interests", "I like / I dislike / Tips for talking to me" and, "My critical care and support needs" were also blank. This information, had it been recorded, would enable staff to engage with the person better and discuss matters based on their life skills and experience.

People's end of life care plans did not evidence people's involvement in decisions. Within the main area of

the service we found that advanced care plans had not always been completed. These plans should detail people's choices in relation to their end of life care. Although one of the plans we saw had been filled in, others had not. Within the Acorns unit we found care records contained a template to develop an end of life care plan. However, as with the main site of the service these were not fully completed to ensure staff knew people's wishes and preferences. When speaking with one member of staff about care plans they told us, "I'm aware that a lot of work is needed on the care plans."

Care records evidenced they had been reviewed, however it was not evident through speaking with people and relatives this had been completed with them. None of the plans we looked at contained any evidence of people or their advocates being involved in their plans. Some people were unaware they had a care plan in place. We spoke with people about reviews of their care. None were aware that they might have a care plan, or that it should be reviewed. One person when asked if they had a care plan told us, "Not to my knowledge - I don't know I have one." Another person asked us, "What is a care plan?" This did not evidence care plans had been designed with the people to whom they referred or their representative. In addition, although the care plans had been reviewed, amendments to plans to reflect people's changing needs had not always been dated by staff showing when and if changes had been made.

People we spoke with, although generally positive, gave examples of when care had not been delivered in accordance with their preferences and others commented on how this was continuing despite raising the matter. One person told us that they were not happy that a, "Young" male staff member helped them with their personal care. They told us they had raised this but were still assisted by male staff. A different person told us, "I don't like men, especially putting me to bed." A further comment was a person who told of their experience at night and said, "One night two men came in - I was embarrassed. I don't mind if there is one woman and one man. They were ok but I didn't feel comfortable." This did not demonstrate that care and treatment had been provided consistently in a way that was important to people and in line with their preferences.

One person explained how they had to spend more time in their room and in bed than they would like. They told us that staff did not get them up until late in the morning and because they had a specific medical requirement they went to bed before 5.00pm. This person had visitors we spoke with who also felt the person should be encouraged to be out of their room more. The person also told us they felt that as they were only up out of bed for the afternoon they did not have time to do things they would like to do.

This was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was a complaints procedure in operation, however it was evident there was room to improve the responsiveness of the current method of complaint handling. For example, one relative we spoke with told us they had made complaints and requests and it had taken a long time for action to be taken. We reviewed the complaints file from March 2016 to June 2017 and there had been 33 recorded complaints. However, the complaints file did not show a consistent approach to complaints handling. The majority did not show that any investigation had taken place or a response had been sent to the complainant. One complainant asked that their complaint about standards of care be, "Escalated to enable it to be dealt with." There was no evidence of any escalation or investigation of the issues raised or a response to the complainant.

People had the opportunity to participate in activities. There were two people responsible for activities and there was a full activities plan for the week. During the inspection, we observed an activities session where eight people were decorating masks with two staff who were supporting them. People were clearly enjoying this, and talked about putting photographs on the services Facebook page. There was a nice atmosphere in

the room and people were clearly engaged and enjoying the activity. During the morning, a number of people had a manicure and nail polish. The people we spoke with who had had a manicure were clearly pleased with the results and enjoyed the interaction. There were a lot of animals kept in the garden for people to take an interest in and three cats. At lunchtime people in the dining room were keen to tell us about the animals and it was evident they had a positive impact on people at the service.

Inadequate

Is the service well-led?

Our findings

At our inspection in September 2016, we identified that systems to assess, monitor and improve the quality of service provided were not always operating effectively. Systems to identify and mitigate the risks to people's health, safety and welfare were not effectively used. The provider wrote to us in December 2016 to tell us how they would achieve compliance with these regulations. During this inspection, we found that insufficient action had been taken and the service remained in breach of the regulation.

It was evident that there were still no effective governance systems in operation that identified medicines practice within the service was unsafe. We identified significant shortfalls during our inspection in relation to the safe use of medicines that had not been identified during current or previous medicines audits. In addition to this, it was apparent that although some governance systems had been used, they had not been used effectively. For example, one care plan audit we reviewed identified actions needed to be taken to the care plan. The actions that arose from these had not always been completed. The audit had been completed on 27/06/2017, but the actions listed such as making the plan more person centred and adding detail to the choking plan had not been completed. This placed the relevant person at risk.

Other auditing systems in operation had not been used effectively or completed. For example, the service completed a monthly pressure ulcer audit. This was in place to monitor the healing progression or any ulcers or skin breakdown and to minimise the associated risks. This audit had not been completed consistently, placing people at risk. From the records we were handed during the inspection it was evident the monthly audit had not been completed in July 2017. The audit for September 2017 had also not yet been completed but we were told this is not completed until the 10 days into the following month. We were unable to establish if an infection control audit had been completed in 2017. We found two audits for 2016 that had been completed. We found a third audit, however this was undated and unsigned so we could not establish who completed it and when. The infection control audit showed actions were required in relation to safe management of needle stick, bite or splash injuries but we could not establish if these actions had been addressed.

Although there were systems that reviewed care records, it was not evident these were effectively monitoring the contents and accuracy of the records. For example, an effective governance system would have identified the shortfalls we have evidenced within this report. A robust system that monitored the accuracy and content of care records would have ensured care plans contained relevant information in relation to risk management for falls, moving and handling and skin breakdown as we identified in the 'Safe' section of this report. Effective monitoring would have identified that there was no evident system to monitor Deprivation of Liberty applications and that Mental Capacity Act 2005 documentation was missing or poor. A governance system to monitor records would also have identified the shortfalls highlighted in the 'Responsive' section of the report and ensured care and treatment was delivered in line with people's preferences.

The service received governance checks from the provider's senior management, however although this was completed it was not clear how these systems had impacted positively on the service. We received the

recent provider level audit that was completed by the clinical and governance lead in April 2017. This audit had identified significant areas of concern in the homes practice. This audit covered clinical practice in the service. Within the audit, we found the auditor had identified issues in wound care management in relation to care plans not being created and recording errors. In addition to this, it was identified people's care needs were not being met and infection control issues including bedrooms being a, "Shocking" state and boxes for the safe disposal of needles being overflowing placing staff and people at risk.

Other poor practice areas identified were, "Messy and disorganised" record keeping and unrequired agency staff being used. Further failings were identified in relation to inappropriate delegation of junior staff to update records and plans with no evidence of them being checked by a nurse. Despite these shortfalls being identified, there had been no action plan produced to address the shortfalls. The audit did show the shortfalls were communicated to the former deputy, however due to the previous registered manager and deputy manager no longer being employed at the service this continuity had been lost. There was no evidence a further audit had been completed to monitor the shortfalls and to identify if improvements had been made.

This was a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Improvements were needed to ensure the provider met their full regulatory requirements in relation displaying the rating awarded to them by the Care Quality Commission (CQC). There is a legal requirement for a provider to display their CQC location rating 'conspicuously' and 'legibly' within the service and on their website (if applicable) where people will be able to see it. This is to ensure the public can make informed decisions on choosing a care provider. On arrival at the service, we identified the previous inspection rating was not being displayed either outside or within the service. The provider had placed the rating for the service on their website. The senior manager present during the inspection told us they would ensure the rating was displayed.

During our conversations with people, it was evident that there was little or no understanding of the current management structure within the service. This indicated that an improvement in communication was required to ensure people knew who was responsible for their care. People did not appear to know about the current management of the service and did not appear to have been asked about their views on the service. One person told us they were unhappy with the staffing levels told us they did not know if staff had listened to the concerns they had raised. They told us, "There are not enough regular ones to listen to you." A relative told us however that the clinical and governance lead seemed knowledgeable.

We spoke with staff and people about resident meetings. One member of staff we spoke with told us that there have been resident meetings in the past but that, "It's fallen by the wayside" recently. One person we spoke with about meetings told us, "They do but I've not been to them." Another person commented when asked about meetings, "I don't know if they do or not. They should do to give our point of view - they could do with improvements, the girls are overworked."

Despite recent pressures of staffing concerns and management changes, staff we spoke with appeared optimistic about the future of the service. Staff told us they felt the change of management at the service, which included a new manager and deputy manager, would have a positive outcome for the service and the people living within in. Staff said they felt morale was improving and they spoke positively of the new manager. One staff member said, "There's been a lack of leadership, but it's getting better." Another positive comment we received from a staff member was, "We've got good leadership now, so morale is much better."

Two other members of staff we spoke with enjoyed working for the organisation. One had been working at Oak Lodge for two years and said, "I love it". They were enthusiastic about interacting with the people living at Oak Lodge and felt that they were valued as a staff member. The other staff member was also enthusiastic about the things that they did with people and was able to talk about how they helped their social interaction and improved their wellbeing.

We saw there were methods to communicate with staff. General staff meetings had been held, and in addition a meeting with a senior member of the provider's staff was held when staffing issues had been raised. The last available minutes for a general staff meeting were dated July 2017. These minutes showed that matters such as management changes, staff being thanked for efforts, sickness, care practice and activities were discussed. A meeting in June 2017 with the senior manager showed interim management arrangements were communicated, together with staffing, the use of a dependency tool and the concerns raised with the CQC by staff.

A relatives meeting had been held in August 2017. We reviewed the minutes for this meeting that showed staffing issues were raised by people's relatives and examples of how this had impacted on people's care and dignity were raised. This is covered in the 'Caring' section of this report. During the meeting, senior management communicated that staffing issues were often down to short notice sickness and that this was a primary reason for issues. Other issues raised by relatives in this meeting were the current management changes and poor management, complaints that had been made, care plans not being updated and reviews not being completed timely.