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Oakendale Residential Care Home

Inspection report

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Ratings

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

Overall summary

The inspection took place on 25 June 2015. Our last inspection of this service was on 11 April 2013, when the provider was meeting all the requirements of the regulations we inspected against.

Oakendale is a small care home accommodating up to fifteen older people. The home supports people to live as independently as possible in a large, three floor, domestic house in the community. The house has been adapted to support people with physical disabilities and includes a lift and stair lift.

The home had a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like

Summary of findings

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.

People, and their relatives, whom we spoke with did not raise any concerns about their safety or that of their loved ones. However, people did raise concerns about staffing levels and the time they had to wait for assistance, due to staffing.

We found there were not sufficient numbers of suitably qualified, competent and experienced staff deployed at all times. Staff had not received adequate training to enable them to undertake their duties. These matters were in breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

People's medicine administration records showed that people received their medicines as prescribed. However, we witnessed poor practice with regard to preparing one medicine and found checks on medicines were not sufficient to ensure they were managed properly and safely. This was in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found the home to be generally clean and tidy. However, we observed some poor infection control practices during our inspection and found that some areas of the home could not be thoroughly cleaned and disinfected. We also found that risks to people's safety and wellbeing were not thoroughly assessed and appropriately managed. This was in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered person had not ensured that staff understood their responsibilities with regard to the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards. People's consent to care and treatment was not recorded. This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The home had not followed correct procedure in issuing themselves an urgent authorisation whilst a standard DoLS application was being processed. Which meant that, for a period of time, a person had been unlawfully restricted and deprived of their liberty which was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People we spoke with and their relatives expressed dissatisfaction with regard to the food provided by the home. People had not been involved in choosing what food they would have liked to see on the menu. The majority of the food provided was supermarket 'own brand'. Concerns were raised that some items of food were not available at weekends. This was in breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found the premises were not adequately designed and maintained. People expressed concerns about accessing the garden to the rear of the home, because of the risk of slips, trips and falls. The garden and patio areas to the rear of the property had uneven surfaces and a step up onto the lawn. Additionally there was broken plastic furniture in the garden and the fire escape had not been properly maintained. This was a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found the activities provided by the service were not personalised and meaningful to those people who lived there, nor did they reflect their preferences. People had not been supported to maintain their interests and community involvement when they had moved into the home. This was in breach of Regulation 9 of the health and Social Care Act (Regulated Activities) Regulations 2014.

The lack of appropriate systems and audits to assess, monitor and improve the quality of the service provision amounted to a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had not formally notified us of a period of absence of the registered manager that would last or had lasted longer than 28 days. This is in Breach of Regulation 14 of the Care Quality Commission (Registration) Regulations 2009.

We were unable to find evidence to show that people were regularly involved in reviews of the care delivered to them. We have made a recommendation about this.

Summary of findings

Staff we spoke with told us they would not hesitate to report suspicions of abuse or any bad practice. The home had implemented a suitable policy and procedure with regards to safeguarding people who were vulnerable by virtue of their circumstances.

We found the provider followed robust recruitment processes which included background checks to help make sure only suitable staff were employed at the home.

Risk assessments and risk management plans were in place, which helped to identify and minimise risks to people's health and wellbeing. These were updated regularly and in line with changes in people's needs.

Staff told us and records showed that staff received an annual appraisal and regular supervision sessions. This gave staff and management the opportunity to discuss performance, training and development needs and aspirations.

People we spoke with told us and records we looked at confirmed that there were a range of healthcare professionals involved in people's care. This helped to ensure that people's healthcare needs were met consistently.

People we spoke with and their relatives told us that staff were kind, sensitive and caring. None of the people who lived in the home, their visitors or the staff we spoke with raised any concerns about the approach of staff. People told us staff respected their privacy and treated them with dignity. We witnessed this throughout the inspection.

We found that written plans of care were person centred and regularly reviewed. They contained a thorough pre-admission assessment which highlighted people's needs, likes and dislikes. The result of the assessment was then used to draw up plans of care to help ensure people's individual needs were met fully. We saw that plans of care and assessments of people's needs were updated regularly, or when people's needs changed. We did, however, find a lack of information in people's care plans about life histories, aspirations, interests and activities. This information would help to better inform the service about how people would prefer their social needs to be met.

People told us they felt able to raise concerns with the registered manager and were confident they would be dealt with appropriately. However, concerns that relatives had raised about the food provision had not been acted upon accordingly.

Staff told us they felt well supported by the management and were able to raise concerns or make suggestions about how to improve the service. Staff meetings took place every three months.

Although there were systems to assess the quality of the service provided in the home, we found that these were not always effective. The systems had not ensured that people were protected against some key risks described in this report about inappropriate or unsafe care and support. We found problems in relation to cleanliness and infection control, premises, staffing levels, medicines, nutrition and staff knowledge around the MCA.

All the staff we spoke with told us they had a commitment to providing a good quality service for people who lived at the home. Staff confirmed they had handover meetings at the start and end of each shift, so they were aware of any issues during the previous shift. We found the service had clear lines of responsibility and accountability. However, we found that during the registered manager's absence, this was not the case.

You can see what action we have told the provider to take at the back of the full version of the report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not always safe.

Sufficient numbers of staff were not deployed at all times.

We found checks on medicines were not sufficient to ensure their proper and safe management.

We observed some poor infection control practices and areas of the home that could not be thoroughly cleaned and disinfected.

Is the service effective?

Requires improvement

The service was not always effective.

Staff had not received adequate training for them to undertake their duties. Staff did not understand their responsibilities with regard to the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards.

People were not satisfied with the food provided by the service and had not been involved in planning the menu.

We found the premises were not adequately designed and maintained. The garden and patio areas to the rear of the property had uneven surfaces and a step up onto the lawn. Additionally there was broken plastic furniture in the garden and the fire escape had not been properly maintained.

Is the service caring?

Good

The service was caring.

We received positive feedback from people and their relatives about how caring staff were.

During our inspection we witnessed kind, sensitive and compassionate interactions between staff and people who used the service.

People's privacy and dignity was respected and promoted.

Is the service responsive?

Requires improvement

The service was not always responsive.

People's needs were thoroughly assessed and plans of care devised to help ensure their needs were met.

However, there was a lack of detail gained around people's life histories, preferences and interests.

People were not provided with opportunities to engage in activities that were meaningful to them.

Summary of findings

Is the service well-led?

The service was not always well-led.

Staff felt well supported by the manager and were able to influence how the service was run.

Systems designed to assess, monitor and improve the quality of the service were not operated effectively.

Staff displayed a commitment to providing a good quality service for people who lived at the home.

Requires improvement

Oakendale Residential Care Home

Detailed findings

Background to this inspection

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

The inspection took place on 25 June 2015 and was unannounced. This meant the provider did not know we would be visiting the service.

The inspection was carried out by an adult social care inspector and a specialist professional advisor in the field of care for older people and those living with dementia.

Before the inspection, we reviewed all the information we held about the service, including notifications of significant events and spoke with the local authority to gain a balanced overview of the experience of people who used the service.

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, what the service does well and improvements they plan to make.

During the inspection, we spoke with eight people who used the service and two of their relatives. We also spoke with five staff members, including the registered manager.

Throughout our visit we carried out observations, including how staff responded to people and provided support. We observed daily activities being carried out and viewed all areas of the home.

We closely examined the care records of three people who used the service. This process is called pathway tracking and enables us to judge how well the service understands and plans to meet people's care needs and manage any risks to people's health and wellbeing.

We reviewed a variety of records relating to the management of the service, including some policies and procedures, safety and quality audits, staff personnel files and training records.

We also reviewed information that was shared with us from other sources including the Local Authority and Clinical Commissioning Group.

Inadequate

Is the service safe?

Our findings

People, and their relatives, whom we spoke with did not raise any concerns about their safety or that of their loved ones. However, people did raise concerns about staffing levels and the time they had to wait for assistance, due to staffing. People also expressed concerns about accessing the garden to the rear of the home, because of the risk of slips, trips and falls.

At the time of our visit, there were 13 people who used the service. They were supported by two carers, one cook and one housekeeper during the day, plus the registered manager was on site Monday to Friday. At night, there was one member of staff on site to provide people with support. People told us, since the new provider took over the service, staffing levels had been reduced and they felt this had a negative impact on the length of time they had to wait for assistance. One person told us; "There used to be more staff, now you have to wait longer." A relative we spoke with explained; "There are usually two [care] staff for 15 people and the home is split over three floors."

We discussed staffing levels with the registered manager and staff. They told us they felt there were usually enough staff to make sure people's needs were met. The registered manager told us they did not use a formal method to calculate staffing levels, based upon people's levels of dependency.

The home was split over three floors, with a communal lounge and dining room on the ground floor. We saw that some people chose to stay in their bedrooms on the upper floors. This meant that if people on the first and second floors required assistance from care staff, there were no staff on the ground floor to assist people if they required it. In addition, one person raised concerns about not being able to get out into the garden, as they required assistance from staff and had to wait "some time".

People we spoke with, and their relatives, raised some concerns about staff turnover. We were told that a lot of staff had recently left the service and people felt this had impacted negatively on the consistency of care that they received. We discussed this with the registered manager who told us they had recently dismissed one carer and several others had left to take up employment elsewhere. Exit interviews had not been held with staff to establish their reasons for leaving.

The matters above amounted to a breach of Regulation 18(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at how the service managed people's medicines, to ensure they received them safely. We looked at a sample of medicines administration records (MARs), spoke with staff, people who used the service, their relatives and observed medicines being administered. No-one we spoke with raised any concerns about medicines. One person who used the service chose to administer their own medication. We saw that appropriate risk assessments were in place regarding this, which were regularly reviewed.

The MARs we looked at showed that people received their medicines, as prescribed. During our observations, we saw staff generally administered medicines safely. However, we witnessed a member of staff administering a medicine which needed to be mixed with a specific amount of water. The staff member did not measure the water and, as such, the medicine was not prepared correctly. We pointed this out to the staff member who immediately rectified the problem and also raised this with the manager during feedback.

Before staff were allowed to administer medication, they underwent training to provide them with the skills and knowledge they needed to do so safely. Training records we reviewed showed that staff had recently completed refresher training on administering medicines, however, the training matrix did not detail all the staff employed by the service at the time of our visit. The registered manager told us they needed to update it, to account for staff who had left and those that had joined the staff team.

In addition to training on medicines administration, the registered manager observed staff administering medicines to check their competence, before they were allowed to do so independently. However, these checks were not recorded and the registered manager was unable to provide evidence that the checks took place.

The registered manager had recently implemented a medicines audit, following an investigation into medicines errors. We looked at the audit and found they undertook a check on each person's MAR to highlight any mistakes or omissions. However, in discussion with the registered manager, it was apparent that no cross-check with medicines stocks took place. This would help to ensure

Is the service safe?

that medicines were administered according to prescriptions, as stocks should tally with MARs. The registered manager told us they had recently requested support from the local pharmacy with regard to medicines management and auditing. This would help to ensure the systems and practices in the home were safe.

The matters above amounted to a breach of Regulation 12 (2) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at people's written plans of care and assessed how the service addressed risks to people's safety and wellbeing. We found systems were in place which helped to ensure that any risks to people were identified and clear guidance was available for staff on how to care for people in a safe manner.

Risk assessments and risk management plans were in place for areas such as moving and handling and nutrition. We saw evidence that assessments and plans were reviewed monthly, or in line with changes in people's circumstances. For example, if a person suffered a fall, risk assessments were updated immediately and further monitoring was implemented.

However, following our inspection visit we received information from the Local Authority which raised serious concerns about how risks to some people's safety and wellbeing were assessed and managed. These concerns were brought to light during Local Authority reviews of people's care packages. The information received showed that during the registered manager's absence, risk assessments and written plans of care had not been reviewed and updated to reflect people's current circumstances. We were also given details of call bells that were not working correctly, which meant people were unable to summon help when they needed it.

For example, one person who was at risk of choking, because of difficulties they had with swallowing, was given a normal diet and was not provided with staff supervision whilst eating. There was no record of a referral to a Speech and Language Therapist for advice and guidance to minimise the risks to this person.

In addition, other people's written plans of care did not contain plans around communication, mobility, personal hygiene or nutrition. This gave rise to concerns that people may not be receiving care in a safe way as staff did not have guidance sufficient to follow for them to carry out their role.

This was in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service employed a housekeeper, to ensure the premises were kept clean and tidy. We asked them to show us around areas of the home and spoke with them about their duties. They told us they felt they had enough time and resources to carry out their responsibilities and keep the cleanliness of the home at a good standard.

We toured all areas of the home and found the home to be generally clean and tidy, however there were strong mal-odours present in several areas. The housekeeper told us they struggled to combat the odours in some areas of the home and had raised this with the manager.

We found one of the en-suite shower rooms was carpeted. This meant the floor could not be thoroughly cleaned and disinfected. There was inadequate sealing around the bath. The sink near the toilet off the main lounge was also inadequately sealed as was the flooring in a different en-suite, where there were also gaps in the wooden boxing around pipework. This meant these areas could not be thoroughly cleaned and disinfected, which posed an infection control risk to people who used the service, staff and visitors.

During our tour around the home, we also found a soiled continence pad, which had been left in the corner of a bedroom and soiled cushion on a chair in the lounge, which staff had not noticed. We pointed these matters out to staff who rectified them immediately.

We found the clinical waste bin was stored in the garden to the rear of the property. The bin was not kept locked, which was not in line with best practice.

The matters above amounted to a breach of Regulation 12 (2) (h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff we spoke with explained that they received training during their induction and periodic refresher training, which helped them to safeguard people who were vulnerable by their circumstances. Training like this helps staff to recognise forms of abuse and informs them of what action they should take in the event they suspect or witness abuse. Staff we spoke with were able to identify abuse and knew how to report any incidents. Training records we reviewed confirmed what staff had told us in

Inadequate

Is the service safe?

respect of the staff who were on the records. However, some staff were absent from the training records, so we were unable to confirm whether they had received this training. The registered manager confirmed all staff had received the training, but they had not yet updated the records to account for new staff and those that had left the staff team.

Staff we spoke with told us they would not hesitate to report suspicions of abuse or any bad practice. The home had recently dismissed a member of staff due, in part, to an incident where a person who used the service had been subjected to verbal and psychological abuse by a member of the care staff. The abuse was reported by staff, in line with the service's policies and procedures, and action was taken against the member of staff as a result. This showed the service took action to safeguard people who used the service from abuse.

We looked at a selection of staff personnel files and found the registered manager followed robust recruitment procedures. In all the files viewed, we noted there had been a thorough process followed, which ensured a variety of background checks were carried out, prior to an applicant being offered employment. These included a full employment history, previous employment or character references and a DBS (Disclosure and Barring Service) check which would highlight any previous criminal convictions and if the individual had ever been barred from working with vulnerable people. The thorough recruitment process helped to minimise the risk of unsuitable people being employed to work at the service.

Requires improvement

Is the service effective?

Our findings

We spoke with people, their relatives, staff members, management and reviewed records to establish whether people were supported effectively, by staff who had sufficient skills and knowledge to undertake their role. We also received information from the local authority with regard to what they had found out about training during a recent investigation.

We looked at staff training records to see what training had been undertaken. The registered manager was only able to provide us with a limited amount of information about staff training. The training matrix they used to record staff training had not been updated recently, which meant it did not account for staff who had left the service or those who had recently joined the staff team. The manager was able to provide us with some certificates of training, for some staff, but these did not demonstrate the training the entire staff team had undertaken.

In discussion, the registered manager admitted that staff training was an area in which they needed to improve. They told us that they really struggled to get funding from the provider for training courses and had to rely upon free courses in the locality. This meant that staff did not receive adequate training to ensure they had sufficient skills and knowledge to undertake their role.

The training matrix we looked at showed that a number of care staff had not received basic training in areas such as food safety, infection control, fire safety or moving and handling. In addition, the only staff member to have received training in first aid was the registered manager. This meant that outside of the hours they worked, there was no member of staff at the home who could administer first aid in the event of an accident or injury.

This was in breach of Regulation 18 (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff told us and records showed that staff received an annual appraisal and regular supervision sessions. This gave staff and management the opportunity to discuss performance, training and development needs and aspirations.

The Care Quality Commission (CQC) is required by law to monitor the operation of Deprivation of Liberty Safeguards. We discussed the requirements of the Mental Capacity Act (MCA) 2005 and the associated Deprivation of Liberty Safeguards (DoLS), with the registered manager. The Mental Capacity Act 2005 (MCA) is legislation designed to protect people who are unable to make decisions for themselves and to ensure that any decisions are made in people's best interests. Deprivation of Liberty Safeguards (DoLS) are part of this legislation and ensure where someone may be deprived of their liberty, the least restrictive option is taken.

Staff we spoke with told us and the registered manager confirmed that no staff had undertaken training on the Mental Capacity Act 2005 or the Deprivation of Liberty Safeguards. The registered manager also had a limited understanding of recent high court rulings in relation to DoLS. This meant the service was not following the MCA code of practice and making sure that the rights of people who may lack mental capacity to take particular decisions were protected.

The local authority informed us of a case where the service had been restricting the liberty of one person who repeatedly left the home on their own. The home had not undertaken any capacity assessment, nor had they submitted any application for authorisation under DoLS, prior to the visit from the local authority, when they were advised to contact the DoLS team for advice.

During our visit, we found that an application had been made under DoLS for the person above. However, the home had not followed correct procedure in issuing themselves an urgent authorisation whilst the standard application was being processed. Which meant that, for a period of time, this person had been unlawfully restricted and deprived of their liberty which was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at care records which showed people were not formally asked for their consent to care. The registered manager confirmed this. This meant that the service relied on implied consent to providing care for people who lived there. The service did not routinely carry out assessments with regard to people's capacity to consent to care.

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

We received mixed comments from people with regard to the design and decoration of the home and its garden. One

Requires improvement

Is the service effective?

person who had recently moved from an upstairs to a downstairs room told us they were "so pleased with the decoration of the room". They told us they had been consulted before the room was decorated and were able to have input into how they wanted it to look.

However, other people we spoke with were not so positive. One person told us; "The owner says he's going to decorate, but doesn't." The home was generally in need of redecoration in several areas. For example, the lounge area was quite dull and there were bedrooms where wallpaper had been peeled from the wall and we found the curtain detached from its rail in one room.

The fire escape to the rear of the property was covered in slippery green algae. It was clear it had not been cleaned for some time. Additionally, there were no markings at the edge of each step to indicate where the step finished. This posed a risk to anyone who needed to use the fire escape.

The garden to the rear of the home was accessible via a slope from the conservatory at the back of the property. People we spoke with told us they did not make much use of the garden because of problems with access. The slope from the rear of the property did not have handrails, the surface of the patio was uneven and there was a lip at the edge of the patio on to the lawn. These posed a risk to people's safety in terms of slips, trips and falls. In addition, the garden had broken plastic furniture on the patio, along with an empty spray bottle and a discarded empty can of expanding foam. This showed that the premises were not always suitably designed and maintained to meet the individual needs of people who used the service.

This was a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at how the service supported people to eat and drink enough and maintain a balanced diet. People who used the service did not raise any concerns about the food during our inspection. However, relatives we spoke with expressed concerns about the quality and choice of food and also mentioned that sometimes food seemed to run out at weekends.

We looked at the kitchen and where food was stored in the cellar. We found stocks of frozen vegetables and tinned goods, which were cheap supermarket 'own brand'. We were told by staff that they bought fresh meat in, but that everything else was tinned or frozen. The registered manager explained this was due to funding constraints.

With regard to food running out at weekends, we were unable to ascertain during this visit whether this was the case. However, we were told by a member of staff that to their knowledge, this hadn't happened. They explained that new staff had, on occasion, forgotten to take items out of the freezer to defrost, but there was a cash float available if staff needed to go to a local shop to buy food products. This, however, would involve the manager or senior carer being called to the home at evenings or weekends, as they were the only ones who had access to the float.

People we spoke with and their relatives, expressed dissatisfaction with the menu that was available. We were told that people or their relatives were not consulted with regard to menu choices and, despite this being raised with the management and the provider, no changes had been made.

We observed people eating in the dining room and saw there was a relaxed atmosphere over the lunchtime period. People were also offered tea and biscuits during the afternoon. However, we did not observe people being offered drinks or snacks at any other time.

In addition, we received information from the local authority which showed that people who were diabetic did not have nutritional care plans in place. Staff did not fully understand how nutrition and hydration may affect people with diabetes.

This was in breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People we spoke with told us and records we looked at confirmed that there were a range of healthcare professionals involved in people's care. This helped to ensure that people's healthcare needs were met consistently. However, we were told by the registered manager that they had recently been experiencing difficulties in arranging for a chiropodist to visit the home. They were currently exploring other avenues of getting this support.

Good

Is the service caring?

Our findings

People we spoke with and their relatives told us that staff were kind, sensitive and caring. None of the people who lived in the home, their visitors or the staff we spoke with, raised any concerns about the approach of staff. People told us staff respected their privacy and treated them with dignity. We witnessed this throughout the inspection.

Throughout our inspection we saw that people were treated with respect and in a caring and kind way. The staff were friendly, patient and discreet when providing support to people. We saw that all the staff took the time to speak with people as they supported them. We observed many positive interactions and saw that these supported people's wellbeing. One person who had been using the service for many years was moving to a different home on the day of our inspection, because their needs had increased in complexity. We observed staff carefully and sensitively assisted the person during the transfer and supported many other long-term residents to say farewell.

We looked at how people were involved in making decisions about the care they received. People told us they were able to make day-to-day decisions about what staff helped them with. People we spoke with were unable to tell us whether they were involved in formal reviews of their written plans of care. We looked at three people's written plans of care and could not find evidence of their regular involvement in reviewing them. We discussed this with the registered manager who told us they tried to involve people, or those close to them, as much as possible, but did not routinely record such discussions. They gave us assurances that they would review the process for recording people's involvement following our inspection.

All the staff we spoke with said people were well cared for in this home. They said that they would challenge their colleagues if they observed any poor practice and would also report their concerns to a senior person in the home and were confident they would be listened to. An example of this was a recent incident where care staff had witnessed another member of staff treating people inappropriately. They had reported the incident to the manager immediately. Following an investigation, the member of staff was dismissed.

People we spoke with, and their relatives, told us that they were able to receive visitors whenever they wanted. They said there were no restrictions on the times they could visit the home.

Throughout our inspection we saw that staff in the home protected people's privacy. They knocked on the doors to private areas before entering and ensured doors to bedrooms and toilets were closed when people were receiving personal care.

People were supported to make sure they were appropriately dressed and that their clothing was arranged properly to promote their dignity.

People were supported to be as independent as possible. We saw them being encouraged to do as much for themselves as they were able to. For example, some people used walking frames to maintain their independence. Staff knew which people needed pieces of equipment to support their independence and ensured they were provided when people needed them.

Requires improvement

Is the service responsive?

Our findings

We found that some aspects of the service were not always responsive to people's needs. We spoke with people, their relatives, carried out observations and looked at written plans of care and associated documentation for three people who lived at the home. We also reviewed information which had been shared with us from the Local Authority following our inspection visit.

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

We found that written plans of care were regularly reviewed. They contained a thorough pre-admission assessment, which highlighted people's needs, likes and dislikes. The result of the assessment was then used to draw up plans of care to help ensure people's individual needs were met fully. We saw that plans of care and assessments of people's needs were updated regularly, or when people's needs changed. We did, however, find a lack of information in people's care plans about life histories, aspirations, interests and activities. This information would help to better inform the service about how people would prefer their social needs to be met.

In addition, following our inspection, we received information from the local authority which showed how during an extended period where the registered manager was absent, risk assessments and plans of care had not been reviewed or updated. This meant the service did not hold up to date and accurate records and guidance for staff to meet people's current needs.

The home had not employed an activities coordinator at the time of our inspection. People we spoke with mentioned some activities that took place around the home, for example, armchair exercises, which we witnessed during the inspection, music days and watching television. There was an activities list on display in the dining room, but we were informed by people and their relatives that they were not satisfied with the activities that were provided. We were told by the registered manager and staff that two trips out had been arranged for the summer, one was a barge trip and the other to the set of Coronation Street. We were unable to ascertain how involved people had been in choosing these trips. A relative we spoke with raised concerns that people did not receive much stimulation. They explained that people had only been out of the home once this year, earlier in June, that they were unable to use the garden due to the hazards presented by the design and that there were not enough staff to support people to go out into the community on a regular basis, if they wished to do so.

We spoke with the registered manager about the points that had been raised with us. They explained that the home had an improvement plan which took into account the design of the garden. They were unable to provide us with a copy of the plan or a timescale for the garden to be altered to accommodate people who used the service safely. They also confirmed that the funding they had for staffing meant they could not regularly support people to go out into the community to be involved in activities. They told us about other activities which were provided at the home, such as the visits from the local church, bingo, quizzes and local choirs that visited during festive periods.

During the absence of the registered manager, people's written plans of care had not been reviewed and updated according to their current circumstances and preferences. We found the activities provided by the service were not personalised and meaningful to those people who lived there, nor did they reflect their preferences. People had not been supported to maintain their interests and community involvement when they had moved into the home. This was in breach of Regulation 9 of the health and Social Care Act (Regulated Activities) Regulations 2014.

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

Requires improvement

Is the service responsive?

The registered manager told us they would usually spend a high proportion of their time 'on the floor' so they could interact with people who used the service. They told us this enabled them to ask people for their views and opinions about the care they received. People we spoke with confirmed this. We were told by the registered manager that they held residents and relatives meetings every three months, but that there was very little interest from people who used the service or their relatives. They also told us they had been conducting satisfaction surveys every three months, but had not received any responses. When we asked why they thought they got such a low response, they explained it was because they were in the home five days a week and speaking with people five days a week to find out if people were satisfied. However, we found concerns that had been raised with management and the provider about food provision had not been acted upon accordingly. The registered manager acknowledged this was a problem area, but told us they had funding constraints to adhere to.

Requires improvement

Is the service well-led?

Our findings

Staff told us they felt well supported by the management and were able to raise concerns or make suggestions for how to improve the service. Staff meetings took place every three months.

During discussions with the registered manager they explained they had recently completed a full audit of the home, but were unable to evidence this. They told us they undertook regular checks on a daily, weekly and monthly basis to make sure the service was running safely and meeting people's needs. The registered manager confirmed there was no audit carried out with regard to people's written plans of care and that the last infection control audit had been over twelve months ago.

Following our inspection, the registered manager was absent for an extended period of time. During their absence, there was a lack of management support or carrying on of management functions at the home. This showed the provider had not ensured that contingency measures were in place in case of such circumstances. We received information from the Local Authority in which staff described the situation as "muddling through" in the absence of the registered manager.

We found the staffing levels at the home were not sufficient to ensure people received safe care and treatment in a timely manner. This showed that the provider had not ensured resources were assessed and provided in line with people's individual needs.

Additionally, the issues we identified regarding the environment, food provision and staff training showed a lack of investment in these areas by the provider.

Although there were systems to assess the quality of the service provided in the home, we found that these were not always effective. The systems had not ensured that people were protected against some key risks described in this report about inappropriate or unsafe care and support. We found problems in relation to cleanliness and infection control, premises, staffing levels, medicines, nutrition and staff knowledge around the MCA.

The lack of appropriate systems and processes to assess, monitor and improve the quality of the service provision amounted to a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

With regard to the absence of the registered manager, we did not receive a formal notification from the provider that the manager's absence would last or had lasted longer than 28 days. This is in Breach of Regulation 14 of the Care Quality Commission (Registration) Regulations 2009.

All the staff we spoke with told us they had a commitment to providing a good quality service for people who lived at the home. Staff confirmed that they had handover meetings at the start and end of each shift, so they were aware of any issues during the previous shift. We found the service had clear lines of responsibility and accountability. However, this was not the case during the registered manager's absence.

All of the people we spoke with, and their relatives, told us that they would be happy to raise concerns about the service provided. Each person knew who the registered manager was and said they were approachable.

We found the atmosphere in the home was open and inclusive. Staff spoke with people in a kind and friendly way and we witnessed many positive interactions between staff and people who lived in the home.

The organisation had a whistle blowing policy in place. This meant staff were able to raise issues with outside organisations, such as the Local Authority or the Care Quality Commission and were protected when doing so.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing Sufficient numbers of suitably qualified, competent, skilled and experienced persons were not deployed at all times. Regulation 18 (1). Persons employed by the service had not received appropriate training, as was necessary for them to carry out their duties. Regulation 18 (2) (a).

The enforcement action we took:
Where we have identified a breach of regulation during inspection which is more serious, we will make sure action is taken. We will report on any action when it is complete.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment People were not protected against the risks associated with medicines by the proper and safe management of medicines. Regulation 12 (2) (g). The provider had not ensured people received care in a safe way by assessing risks to the health and safety of service users, nor had they done all that was reasonably practicable to mitigate any such risks. Regulation 12 (2) (a) (b). The registered person had not ensured effective systems were in place to assess the risk of, prevent, detect and control the spread of infection. Regulation 12 (2) (h).

The enforcement action we took:
Where we have identified a breach of regulation during inspection which is more serious, we will make sure action is taken. We will report on any action when it is complete.

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

This section is primarily information for the provider

Enforcement actions

The registered person had not ensured staff understood their responsibilities with regard to the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards. Formal consent to care and treatment was not recorded. Regulation 11 (1) & (3).

The enforcement action we took:
Where we have identified a breach of regulation during inspection which is more serious, we will make sure action is taken. We will report on any action when it is complete.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA (RA) Regulations 2014 Meeting nutritional and hydration needs The nutritional and hydration needs of service users had not been met with regard to the meeting of reasonable requirements arising from service user's preferences. Regulation 14 (4) (d).

The enforcement action we took:
Where we have identified a breach of regulation during inspection which is more serious, we will make sure action is taken. We will report on any action when it is complete.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment Premises and equipment used by the provider were not clean, suitable for the purposes for which they were being used or properly maintained. Regulation 15 (1) (a), (c) & (e).

The enforcement action we took:
Where we have identified a breach of regulation during inspection which is more serious, we will make sure action is taken. We will report on any action when it is complete.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care

This section is primarily information for the provider

Enforcement actions

People's written plans of care had not been reviewed and updated according to their current circumstances and preferences.

People were not able to participate in meaningful activities according to their preferences. Regulation 9.

The enforcement action we took:
Where we have identified a breach of regulation during inspection which is more serious, we will make sure action is taken. We will report on any action when it is complete.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance Systems designed to assess, monitor and improve the quality of the service were not operated effectively. Regulation 17 (2) (a).

The enforcement action we took:
Where we have identified a breach of regulation during inspection which is more serious, we will make sure action is taken. We will report on any action when it is complete.

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 registered person had not ensured they followed the correct procedure with regards to making an application under the Deprivation of Liberty Safeguards. One person had been, for a time, unlawfully deprived of their liberty for the purpose of receiving care and treatment. Regulation 13 (5).

The enforcement action we took:
Where we have identified a breach of regulation during inspection which is more serious, we will make sure action is taken. We will report on any action when it is complete.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 CQC (Registration) Regulations 2009 Notifications – notice of absence

This section is primarily information for the provider

Enforcement actions

The provider failed to inform us of the absence of the registered manager which lasted longer than 28 days.

The enforcement action we took:
Where we have identified a breach of regulation during inspection which is more serious, we will make sure action is taken. We will report on any action when it is complete.