Anchor Trust

Oakleigh

Inspection report

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Ratings

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

Overall summary

Oakleigh provides care and accommodation for up to 50 people who are elderly and are living with dementia. The home, which is set over three floors, is divided into five units; each unit has their own lounge and dining area. Each unit accommodates approximately ten people. On the day of our inspection 46 people were living in the home.

The inspection took place over three days on 23 & 29 January and the 2 February and was unannounced.

The home is run by a registered manager, who was present on the day of the inspection visit. 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 and associated Regulations about how the service is run.

People had different levels of understanding and communication in relation to their Dementia. Staff did

Summary of findings

not show a level of understanding that people living with dementia have specialist needs. We heard staff talking to people with advanced dementia in a non-dignified way using comments such as, "Good girl."

Staff did not have written information about risks to people and how to manage these in order to keep people safe. One person had fallen on several occasions and their risk assessment had not been updated since May 2014 to show the persons increased falls, or identified that the person may need to be referred to the falls team. Another person had been diagnosed with epilepsy, but their care plan did not describe guidance to staff on how to manage the risks of this person having a seizure. Risk assessments and care plans did not reflect the individual need of the person and how their dementia and physical needs affected their daily life.

Staff had received training in safeguarding adults and were able to evidence to us they knew the procedures to follow should they have any concerns. One staff said they would report any concerns to the registered manager. They knew of types of abuse and where to find contact numbers and knew about the local safeguarding team.

Staff did not have the specialist training they needed in order to keep up to date with caring for people who live with dementia and responding to their physical health needs. For example; one person with dementia was also registered blind; staff did not understand how to effectively communicate with the person to give a choice and reduce the person's anxieties.

Staff had not received regular supervision or appraisals. One staff member said; "One staff said they had monthly staff meetings and unit meetings on an ad-hoc basis."

We identified a need for additional members of staff to be on duty as there were times when we found no staff available to assist people or keep them safe for example from the risks of falls, or to support someone if they became distressed. One visiting healthcare professional said they had noticed the home was sometimes very short staffed, more so at the weekends. Sometimes they arrived to find people not up and dressed. When they asked staff about one person, they were told the person didn't have visitors at the weekend which made the healthcare professional feel staff prioritised who they got ready first.

Although people told us they were happy living at Oakleigh, we did not observe staff consistently respecting people and treating them as individual's, focusing on their needs, abilities and achievements. We heard staff ask people constantly about task focused activities e.g. "Would you like a cup of tea, its lunchtime now, come and have your dinner." We did not observe staff sit and talk to people about their life, how they felt or what they wanted to achieve throughout the day.

Staff did not show an understanding of what people were interested in and what people could still do. We saw some people sitting for long periods of time without supportive interaction from staff. Supportive interactions are relationships and communications that we have with people that are affirming and help promote a person's sense of self-worth. Best practice guidance shows one-on-one time is very important to having supportive and emotionally worthwhile social interactions.

Activities were limited to people who had capacity to become involved. We did not see any specific activities or pastimes which would be suitable or appropriate to people living with dementia. One staff said there were not enough activities, "They are arranged but never really see them happen."

The registered manager had taken immediate action to address issues and staff awareness of people's specific dietary needs, following concerns about the support people needed to eat and drink in relation to special diets such as softened food. However not all people's care plans correctly identified the support they required for eating and drinking. We observed lunch which was a choice of two main courses and desserts and it looked and smelt appetising.

People were referred to external health professionals when they needed extra support. One person said; "We get visits from a chiropodist and other professionals."

Care plans did not reflect people's current needs or individualised choices. They had not been reviewed on a regular basis. One person file stated the mobility assessment and Malnutrition Universal Screening Tool (MUST) were completed 28 January 2015, however, the Waterlow assessment (an assessment that identifies the risk to the person of developing a pressure wound), skin integrity and personal care plan were blank.

Summary of findings

Some people were involved with their own plan of care. One person said; “They are very busy but they do speak to me about my care needs.” Other people who lacked capacity had not been involved in their care planning process.

Medicine procedures for the safe administration of medicines were not consistently in place. However we could not identify consistent best practice for the administration and recording of topical creams. Records demonstrating they were applied as prescribed were not up to date.

The legal framework around the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS) had not been followed. Staff understood the requirements of the Act and how it affected their work on a day to day basis. One staff said, “MCA and DoLS is when people don’t have the capacity to make choices.” However the registered manager had not completed the necessary MCA two-stage assessment or applications to the local authority as required by the DoLS. This meant people without capacity had not been supported in agreeing to choices made about their care. People at the home were being restricted from leaving and in aspects of their care.

The registered manager did not have a satisfactory system of auditing in place to regularly assess and monitor the quality of the service or manage risks to people in carrying out the regulated activity. We found the registered manager had not assessed incidents and accidents including falls, staff recruitment practices, care and support documentation, and decided if any actions were required to make sure improvements to practice were being made.

Confidential and procedural documents were not stored safely or updated in a timely manner. We saw copies of the homes contingency and emergency plan and the registered manager was able to explain the process in the event of an emergency.

People’s views were obtained by holding residents meetings and sending out an annual satisfaction survey.

The registered manager showed us the complaints log which detailed concerns raised by people or their relative. We saw that the manager had responded to people’s complaints and implemented actions, where necessary. One person said; “I’ve never complained but would do so” and “They would sort out a problem.”

People felt the management of the home was approachable; One person said “X is the manager and seems to be OK, I see them sometimes” and “They seem to manage the home well.” Staff generally said they felt supported; however felt the registered manager could be more visible on a day to day basis. Comments from staff included; “We don’t see the registered manager much, they spend a lot of time in their office.” And “The registered manager spends a lot of time in the office. Occasionally we see the area manager. Generally I feel supported by management.”

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which correspond to regulations of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of this 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?
The service was not safe.

Risks to people's health and welfare were not always minimised effectively.

Topical medicines were not always managed or administered safely.

The provider had not ensured there were enough staff to meet people's needs.

Staff knew how to recognise the signs of abuse and would report any concerns they had.

Inadequate

Is the service effective?
The service was not effective.

Care records that supported specialist diets were not up to date and did not reflect people's current needs.

Staff were not effectively monitoring people's healthcare needs, particularly when their needs changed.

Staff did not demonstrate best practice in relation to working with people living with dementia.

The registered manager did not understand their responsibilities under the Mental Capacity Act 2005 or Deprivation of Liberty Safeguards. People's freedom was being restricted and there was no system in place to identify if people could make decisions about their care and treatment.

Staff had not received regular supervisions or appraisals.

Inadequate

Is the service caring?
The service was not always caring.

People were positive about the care they received, but this was not always supported by our observations.

People's privacy was respected by the way that care was provided, however people were not always treated in a dignified way.

Some staff showed concern for people in a caring way; however practical action was not always taken to relieve people's distress.

Requires improvement

Is the service responsive?
The service was not responsive

Care plans had not been regularly reviewed to help ensure staff had up to date guidance on people's needs.

Requires improvement

Summary of findings

People were not always supported to take part in activities and there were no individualised activities for people.

People were encouraged to raise their concerns or complaints.

Is the service well-led?

Requires improvement

The service was not consistently well led.

Recent staff changes were impacting on the smooth running of the service.

The registered manager had not always ensured that effective systems were in place to identify and remedy areas of concern or risk in a proactive manner.

People were asked for their views on the service and generally staff felt supported.

Oakleigh

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 23 & 30 January and the 2 February 2015 in response to concerns raised of a serious incident within the home and previous concerns about the numbers of staff supporting people's needs.

On this occasion we did not ask the provider to complete 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. This was because we were responding to information and concerns that had been raised with us.

The inspection was carried out by three inspectors and an expert by experience (ExE). An expert by experience is a person who has personal experience of using, or caring for someone, who uses this type of care service. Our ExE had personal experience of caring for someone who lived in a care home environment.

During the inspection we spoke with six people who lived at Oakleigh, eleven staff, three relatives, the registered manager, and three health care professionals, two social care professionals and the area manager. We observed care and support in communal areas and looked around the home, which included people's bedrooms, the different floors within the building and the lounge and dining areas. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us

We reviewed records held by CQC which included notifications, complaints and any safeguarding concerns. A notification is information about important events which the service is required to send us by law. We had previously received information of concern about the care and welfare of people.

We looked at a variety of documents which included ten people's care plans, seven staff files, training programmes, medicine records, and four weeks of duty rotas, menus and quality assurance records. We also looked at a range of the provider's policy documents. We asked the registered manager to send us some additional information following our visit, which they did.

We last inspected Oakleigh on the 16 December 2013 where we had no concerns.

Inadequate

Is the service safe?

Our findings

One person told us, "I'm very safe, they are kind people here." Another person said, "I have always felt very safe here." and, "All my things are here, it's like home." A relative told us, "She has definitely been safe here." Staff said they kept people safe by, "Following policies and procedures and making sure people had their call bell system. Also checking on people regularly in their room." Despite these comments we did not feel people were living in a safe environment.

People commented on the levels of staff, one person said, "I think there could be more staff, they seem to be rushing around a lot." Another person told us, "Sometimes there aren't staff about, especially on Sunday's and when I ring the bell sometimes they come quickly, other times not but they could be dealing with someone else."

We found the service was not safe because there were not enough staff to care for people or to help keep free from harm. One staff member told us, "No" there weren't enough staff. For example, one person came in yesterday and no assessment has been undertaken of their needs and then another two people moved in." Staff said one person was very anxious about moving into the home and walked constantly asking if they could go home. Staff did not have the correct information to care for the person and said that if more staff were available they would be able to provide greater support to alleviate the person's distress.

Our observations showed there were no staff around on the middle floor from 2.00pm until 2.25pm and on the ground floor in one unit there were no staff around for 20 minutes. During this time people with high dependency needs were left unsupported. We saw that on the top floor people were left unsupported whilst staff undertook other tasks such as washing up and the laundry. One person called out "Hello" several times while other people sat staring out the window.

One staff said mornings were rushed, but evenings were quieter and sometimes they had time to sit with people. One relative said she was not aware of her mother having to wait for staff to assist her. However they said staff were rushed.

On one unit two people had been identified as needing one to one support at mealtimes. We asked staff how this was actioned as only one staff was present to meet the needs of all people; and were told that these people usually had their meal later than others. This isolated people from the main community and meant that people were at risk of not receiving appropriate nutrition at regular intervals.

Each unit had one staff member to support up to ten people with a 'floating' member of staff who could be called upon if needed. We asked staff how they managed people's needs if more than one person needed assistance at a time and we were told, "We have to wait for the floating staff to come and support." One relative told us, they had visited the home at the weekend to find their relative sitting in wet clothes.

The registered manager said there should be nine to ten staff in the morning, eight staff in the afternoon and either four or five staff at night. These numbers of staff included the team leaders who floated between units if assistance was needed. The registered managers said that team leaders also administered medicines which would take them away from direct care three times a day. There was no consistency in the rota whether nine or ten staff worked on any given day.

We looked at the duty rotas and saw there was the assessed level of staffing in the morning. However we saw on the rotas that during the afternoons for a one week period that on four occasions there were only six staff on duty and on three occasion's staff numbers were reduced after 7pm by two staff. This left on two occasions; five staff to support the needs of 46 people for a two hour period until night staff arrived. The rota showed that every night only four staff were on duty throughout the home. The registered manager said they were in the process of recruiting other staff.

We asked the registered manager how they determined the level of staffing for each unit. The registered manger showed us a dependency assessment for people which identified whether the person needed help with personal care and mobility needs from one or two staff. The assessments we looked at showed people needed support from two staff.

Some of these assessments had not been updated to reflect the persons changing needs. For example, one person had been assessed as at risk of developing pressure wounds. The care plan stated the person should be supported in changing position every 2-3 hours. There were no records in place to confirm this support had been

Is the service safe?

provided. We spoke to staff about how they could provide this support if there was only one staff on duty and were told, "We have to wait until someone else comes." The infrequency of turns could increase the risk of the person developing a pressure wound.

There were not enough staff to safeguard the safety and welfare of people and meet individual needs. This was a breach of Regulation 22 of the Health and Social Care Act 2008(Regulated Activities) Regulations 2010, which corresponds to regulation 17 of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014.

People's medicines were not administered as prescribed. Topical applications such as creams and eye drops were not being administered as prescribed to relieve people's discomfort. We saw examples of this for several people. People had creams prescribed to be applied to different areas of skin which were at risk of pressure wounds or dryness. However, records indicated the creams had only been applied once a day in the evening, seven times in the last four months not three times a day as prescribed.

One person had been prescribed creams to alleviate joint pain which should have been applied three times a day but this had only been applied six times since October 2014. A further person had been prescribed cream for their eyes. The direction for this was that it was to be applied daily in the morning. However, recorded entries stated it had been applied in the evening and only three days were recorded.

Staff had not responded to people's changing needs and had not always implemented actions in a timely manner. We had received a notification from the home that one person had been given the incorrect dose of medicines for a period of six weeks. We were told by the registered manager that the GP had visited the person and altered the dose of medicines in December 2014 but staff had not amended the repeat prescription to reflect the person's current medicines.

People were not protected against the risk of unsafe administration of medicines. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 12 (f) & (g) of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014.

Risk assessments had not been updated. People at high risk of falls had been identified but staff were not reviewing their care plans to look at alternative options to prevent or reduce the falls. For example, one person had experienced numerous falls over the past five months but their last fall's risk assessment had not been updated since May 2014 and there were no records to show if anything had been done to help reduce their risk of falls. Another person had been diagnosed with epilepsy, but their care plan did not describe guidance to staff on how to manage the risks of this person having a seizure. Risk assessments and care plans did not reflect the individual need of the person and how their dementia and physical needs affected their daily life and provide accurate information for staff to manage these risks.

Staff did not ensure people were always kept safe. We saw one person's bed had been extended however the mattress was too short for the lengthened bed. This left a gap at the bottom of the bed of 1300mm which could lead to the person's feet being entrapped and /or resting directly on the metal bed frame. We spoke to staff about this who immediately positioned pillows between the mattress and bed end.

Staff files did not contain all the necessary information to help ensure the provider employed people who were suitable to work in the registered provider had not been proactive to addressing issue, but dealt reactively to concerns raised via the inspection process home. We found four staff files did not have completed application forms, two had no references, one had one reference and one had no medical form completed. The registered manager showed us an audit they had undertaken of the staff files which identified further missing information such as application forms and Disclosure and Barring Service (DBS) checks. However, the registered manager had not actioned the shortfalls in the recruitment files. They told us recruitment was coordinated by head office and the area manager gave us assurance this information would have been collected through the recruitment process, we were told these documents had been obtained during the recruitment process but copies had not been sent to the location.

Staff had received training in safeguarding adults and demonstrated to us they had a good understanding of the different types of abuse to be aware of and what to do if they had any concerns.

Inadequate

Is the service effective?

Our findings

People had mixed views about the food. People told us, “The lunch today was not too good” and, “I could ask for an alternative and they would do it” and, “I have enough to drink.” Another person said, “The food is alright” and, “I get a drink most time, I like a large cuppa.”

We had received concerns about the specialist diets people needed following a serious incident at the home. We undertook a responsive inspection on 23 January 2015 in response to these concerns and identified that people’s nutrition care plans were not up to date. They did not reflect people’s current need. The registered manager said three people were on ‘fork mashable’ diets and three people were on a ‘pureed’ food diet. These descriptors are designed by the National Patient Safety Agency (NPSA) Dysphagia Expert Reference Group and detail the types and textures of foods needed by individuals who have swallowing difficulties and who are at risk of choking or aspiration (food or liquid going into their airway). People’s care plans did not accurately describe dietary needs, which could lead to the person being giving the wrong type of food and putting them at risk of choking.

The registered manager was assessing all dietary summaries and checking they held the correct information about each person. They said they had found some anomalies in care records. The correct personalised information had not been passed to the speech and language therapist (SALT) team to enable them to undertake a full assessment of people’s dietary needs. Which meant the correct type of specialist diet may not have been put in place for people.

The registered manager had implemented immediate actions to Ensure that staff were aware of people dietary needs. A folder for the chef/kitchen staff had been put in place and SALT guidance added to folder. Documents about choking risks and specialist diets were in the folder. Food allergy, likes and dislike lists were updated to include everyone living in home, whether having a special dietary requirement or not.

The registered manager said staff in the kitchen were to inform care staff where the special diets were in the trolley when they delivered it to the unit. However we observed this not to be the case.

We spoke to kitchen staff who were able to describe the new process and told us they had a list in the kitchen of people on specialist diets. They said most people had a sandwich at teatime, but they needed to check on the list to see if that was still correct. Other staff told us information had changed and been updated and they will be disseminating the new information to staff in handovers.

People’s nutritional care plans were not consistently kept up to date; one person food assessment was last updated in May 2014, although they had special dietary requirements which should have been reviewed regularly. Supporting documents such as malnutrition universal screening tool (MUST) were not updated. ‘MUST’ is a five-step screening tool to identify adults, who are malnourished, at risk of malnutrition (under nutrition), or obese. It also includes management guidelines which can be used to develop a person’s nutrition care plan and ensure people’s nutritional needs are met.

Staff were not provided with the correct information to ensure they were providing the correct support or to identify if further support was needed by a person. For example, One person’s health had deteriorated. The registered manager had requested support from external agencies and was reviewing the person’s care to see if they could continue to meet the person’s increasing needs. Charts for food and fluid intake had been implemented; these charts were used to ensure this person received the right' nutrition. However, the charts we looked at had not been completed accurately; one chart had entries from 9.00am until noon but no further entries after that time. We observed there was no chart was in place on the second day of our inspection. The district nursing notes had identified that this person should be ‘encouraged to take fluids.

We observed throughout the day that people were constantly offered a drink, however there was no choice in the drink; staff would just say, “Do you want a cup of tea?” without offering a choice or asking people their preferences.

When the catering trolley came from the kitchen, the kitchen staff didn’t tell the care staff where the special diets were. Staff had to ask. Meals were served up very quickly so people didn’t have to wait. Staff told people what they were being given. Two staff said the food in the trollies was labelled and we saw this to be the case.

Inadequate

Is the service effective?

The provider had not identified risks to people with complex needs in their eating and drinking. This was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 14 and regulation 9 (3)(i) of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty safeguards (DoLS) which applies to care homes. DoLS are part of the Mental Capacity Act 2005 (MCA). They aim to make sure people in care homes are looked after in a way that does not inappropriately restrict their freedom.

Many of the people living in the home were living with dementia. Some had the mental capacity to make their own decisions on a day to day basis, but sometimes this fluctuated. Other people did not have the mental capacity to make their own decisions.

Suitable arrangements were not in place in any of the care plans we looked at for obtaining consent to care or treatment. People were not always involved in their planned support. One person said, "The staff are too busy to talk to me about my care." We read in care plans that people's consent had not been obtained for care or treatment which meant people were not being supported to make decisions and choices about their own care.

We saw that people had bedrails in place and the external doors to the home and the lift were controlled by a key coded pad, this meant people were restricted to the floors they lived on. We did not see any two stage mental capacity assessments which would help determine if a person lacked capacity to make a particular decision or if the use of bedrails was appropriate for the person.

We spoke to the registered manager who stated that no DoLS applications had been submitted to the local authority and individual mental capacity assessments had not been undertaken. This meant that people may have been deprived of their liberty unlawfully. Staff had some knowledge of the MCA. They told us that team leaders and senior staff were responsible for undertaking assessments on people. However we found that these assessments had not been undertaken.

Where people did not have the capacity to consent, the provider was not acting in accordance to legal requirements. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 11 of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014.

One staff said they had been away from the job for five months and since they had been back had not had supervision or refresher training, apart from medication training. Another staff member said "One staff said there was loads of training and it was always interesting."

Management knew the importance of training for staff, and on the whole staff said they received regular training. One staff member said, "One staff said there was loads of training and it was always interesting. However from our observations staff did not fully understand or consistently demonstrate their knowledge in their behaviour and practice towards peoples. For example, a person's behaviour that challenges others increased between dusk and lasts into the night. Staff did not demonstrate coping strategies or an understanding that psychological, social and environmental aspects can exacerbate behaviours and had identified this person as 'aggressive' in their care plan. Staff had not tried to support the person with other activities or to distract the person from the anxieties they showed.

The registered manager said that they were behind with supervisions, due to the recent changes of staff. They gave us a copy of the supervision record for all working care staff; which identified that some staff had not had supervision since July 2014 and a further eight staff since September 2014. This meant that staff had not had the regular opportunity to develop skills through the exchange of information, observation and practical experience or review and discuss individual people's welfare issues.

Staff responded to changes in people's health needs and supported people to attend healthcare appointments such as to the dentist, doctor or optician. One person told us, "The doctor visits weekly and the chiropodist comes monthly" and, "A dentist and an optician also visit" and, "They arrange for me to go and see the dentist at the hospital and they chase it up." A healthcare professional said one person had several pressure sores and staff were fantastic at following their guidance. They added another person was quite distressed and staff moved them to a room with a view out to the front of the home. They said as a result he was a different person and much happier.

Requires improvement

Is the service caring?

Our findings

People had mixed views about the quality of staff, they said, “Their kindness is startling to me” and, “The staff are splendid and patient.” A relative said to us, “The staff are very polite, helpful and welcoming.” Other people held different views. One person said; “It’s a pity staff don’t have much time for people.” Another person stated, “They don’t usually talk to me.”

One healthcare professional said it was a nice place and the staff were very good. They said they felt the level of care was good, but did not feel it was personalised, and it was task focused with staff providing more generic care.

People were not consistently treated with dignity by staff. Although we observed some staff treat people with dignity, we did not always observe this was consistent. A staff member and relative came into the lounge area to ask if anyone owned a particular blanket. One person called out to both of them, but they ignored her. We saw in one lounge the chairs were arranged sideways to the television and two people sitting watching television were craning their necks, but staff did not suggest or support them to move seats.

We observed at lunchtime that care staff stood beside a person who needed support with nutrition, and did not sit next to them. This did not support the dignity of the person in being supported to eat their meal.

We saw staff gather people in the lounge to play a ball game; people were not offered a choice. Staff used words such as, “Sit down” and, ‘You have to come into the lounge.” One person had moved into the home the previous day. They were showing signs of anxiety and walking around saying they wanted to go home. We did not see staff interact with this person or try to alleviate their distress.

One person was inappropriately dressed and had their slippers on the wrong feet. Staff did not support or encourage the person to alter their clothes in order to help maintain their dignity.

Staff did not always spend time with people in a social manner. We did not see many occasions when staff sat and interacted with people. Staff told us that depending on what unit they were in they may not have time to sit with people as people had differing level of needs throughout the home.

The lack of consideration and respect to people is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 10 of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014.

We asked people and family members if they had been involved in their care or the care of their relative. Relatives said they were not always included and kept up to date by the staff at the home. Two people stated they had not seen their care plans or been asked for their preferred choice in aspects of care.

Staff supported people’s privacy when delivering care. They knocked on people’s doors before entering; where people liked their doors to be left open, the staff knocked and called to them before entering the room. One person told us, “They do knock on my door and draw curtains” and, “They respect that I have been through a trauma.” Another person said, “They respect our dignity and I don’t mind a male care worker” and, “I do have visitors and there are no restrictions.”

Requires improvement

Is the service responsive?

Our findings

One person told us, "At the moment we are lacking on entertainment, but it does not worry me as I read a lot." A healthcare professional said in the seven months they had been coming to the home they had never seen any activities going on. They stated they observed people just sitting in their rooms or the lounge.

The registered manager said the home had one activities staff member to support the social needs of up to 50 people. We saw on the rota that extra hours were allocated for a part-time worker as well however this vacancy had not been filled. One staff said there were not enough activities, they told us they are arranged but never really happened. They said, "It's all well and good asking people's life history, but the information is never really used."

Staff said, "There is normally something happening. Some staff encouraged people to take part in sing-a-longs." We spoke to staff about their understanding of social interactions and activities for people with dementia and staff did not have an understanding on the benefits of focusing on the person rather than the task. We did not observe staff promote meaningful activities linked to hobbies or interests that the person enjoyed before the diagnosis of dementia. Activities such as taking a walk, cooking or painting which can help preserve dignity and self-esteem. Not all staff supported people to undertake everyday tasks such as setting the table for a meal or folding clothes.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We saw people sitting in the lounge areas for the majority of the day. On one unit three people were asleep from lack of stimulation. The TV was on however people told us they didn't know why it was on, who put it on and they weren't watching it.

Activities had not been tailored to people's individual needs and limitations. For example, one person who was registered blind and partially deaf was taken to take part in the ball game activity. Staff had not considered how to make the most of the person's sight. Staff did not use descriptive communication which is important to describe what is happening, for example that you have just come into the room, or explain what the person is eating.

The environment lacked stimulation for people living with dementia and did not build on people's remaining skills and talents. For example, labelling cupboards and drawers or using pictures and words. We observed several people in the home walking throughout the day looking for their rooms.

We recommend that the registered manager explores relevant guidance on how to make environments more dementia friendly and to look at guidance about meaningful activities for people living with dementia.

People were invited to the home for a day before they moved in. This was to enable the person to get to know the home, and for staff to gain basic information that would help develop the person's plan of care, and to see if they could meet their needs.

Care plans had not been reviewed regularly and did not always provide clear direction for staff in what care to provide for a person. The registered manager told us that initial care plans should be completed within six hours of a person moving in. However, this had not happened in relation to one person and essential information about their weight, nutrition or skin integrity had not been completed. Which meant staff did not have the correct information about identified risks to the person.

Care plans lacked personalisation and primarily focused on tasks such as personal care and mobility needs. They did not show how the experience of dementia affected them as this varies widely from person to person and they lacked an element of dementia focused care containing information such as memory assessments, biographies and personality traits.

One person had experienced a chest infection, there was no plan of care in place to address this change of need or how staff should support the person whilst their health had deteriorated. In all the care plans we looked at we saw that people's end of life wishes had not been addressed.

All ten people's care records we saw were not completed in full or reviewed regularly meaning staff may have the wrong information about a perceived risk to a person. Care plans showed that elements of people's care, particularly in relation to their weight or skin integrity had not been reviewed since August 2014. Other people's records did not

Requires improvement

Is the service responsive?

have information relating to health status; 'My past and present medical conditions', professional and religious contacts and consent to care and treatment forms were not completed in full.

We also saw examples of information such as medicines, nutritional needs and mobility needs not updated in information packs that were to be used by external agencies and if people need to go to hospital.

This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 9 (3)(a)(b-h) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014. corresponds to regulation

People's views were obtained through feedback questionnaires and resident's meetings. The area manager said the results of the last survey had just been produced and they were in the process of analysing them. They said that overall feedback was very positive. Relatives said, "We had a questionnaire and they seem to send it round yearly" and, "There are resident's meeting where things get sorted."

The home had a complaints policy and procedure which was on display and information about how to make a complaint was in the 'service user guide' which each person had in their room. We looked at the complaints records, these showed us formal complaints were taken seriously, investigated and resolved where possible. The registered manager explained that if a complaint could not be resolved in the home it was escalated to head office. Relatives told us they felt comfortable approaching the management team with issues or concerns. One relative said, "When I asked for a change in something, they have done it." One person said, "They are about to change my bed because it's lumpy."

Requires improvement

Is the service well-led?

Our findings

People said they felt the home was well managed. One person said, "I do see the (registered) manager and staff sometimes." And. "I think this place is very well managed." Another person said, "I see the manager occasionally, she's approachable" and, "The Home is run okay as far as I'm concerned."

Staff felt the registered manager was approachable however they didn't feel they showed a presence in the home enough. However they felt people knew who the registered manager was and she knew them. They said they found her supportive.

The registered manager knew people's name and information about their needs and lives and they interacted with people in a kind and compassionate way. The registered manager said they walked around the home regularly and observed staff interactions and care. However, we had observed staff at times treat people with a lack of dignity and respect which showed us the registered manager needed to be more effective in the day to day management of the home.

The registered manager said that staff supervision to help staff undertake their work were not up to date. They explained that there had been a recent change in staffing and processes needed to be redefined and supervision held regularly to support best practise.

The provider had procedures and documents in place to assess the quality of the service and identify any areas of concern. However the registered manager had not undertaken the audit schedule as requested by the provider. The registered manager said that care plan audits, infection control audits and other audits had not been regularly undertaken. The systems had not ensured that people were protected against some key risks described in this report about inappropriate or unsafe care and support. In relation to care plans that needed reviewing, Infection Control and the Mental Capacity Act 2005. For example; If regular care plans audits had been undertaken they would have identified the lack of appropriate reviews and dietary requirements for people. Monitoring of staff practice in relation to activities would have identified that some people were not being supported to have quality days. This demonstrates that you are not protecting service users against the risk of inappropriate or unsafe care and treatment, as no effective systems are in place to enable you to assess and monitor the quality of the service.

There was no effective system in place to regularly assess and monitor the quality of the service provided which was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

Care records were not kept securely. We observed throughout the day on all units the doors to the rooms containing care records and personal information were left wide open. This may allow other peoples to access these confidential records.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 17 of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014. The health, safety and welfare of service users was not safeguarded because there were not sufficient numbers of staff employed/deployed in the home.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 10 of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014. The respect and involvement of people was not met as staff did not always treat service users with consideration and respect.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 11 of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014. People who use services were not protected because the provider did not act in accordance with legal requirements relating to assessing capacity and consent.

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 14 and regulation 9 (3)(i) of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014 The provider did not ensure people were protected from the risks of inadequate nutrition and dehydration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014. The registered manager did not effectively undertake processes to regularly assess and monitor the quality of the services provided.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 12 (f) & (g) of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014. The registered manager did not protect people from the unsafe use and management of medicines.

Regulated activity	Regulation

This section is primarily information for the provider

Action we have told the provider to take

Accommodation for persons who require nursing or personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 9 (3)(a)(b-h) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014. The registered manager had not ensured that care plans were appropriate, met people's needs or reflected people's preferences.