De Vere Care Limited

Oakwood House Residential and Nursing Home

Inspection report

Oakwood House
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IP5 2GD

Tel: 01473612300

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10 November 2017

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

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

The inspection took place on 8 November and 10 November 2017. The first day of the inspection was unannounced. Oakwood House Residential and Nursing Home accommodates 24 people in one adapted building. At the time of our inspection, there were 24 people living at the service.

There was a registered manager in post. They were registered in June 2017 but had managed the service since December 2016. This was their first post as a manager, although they had worked in the service previously as the deputy manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Oakwood House Residential and Nursing Home is an established care home and was recently registered with the Care Quality Commission on 10 October 2017. However, the change in registration was the result of changes within the provider's organisation. The only change was to the provider's name. There were no other changes to the service. The management and staff team remained the same. However, this was the first comprehensive inspection under this registration and as such they had not yet received a CQC rating.

At this inspection, we found systems for monitoring quality and auditing the service had not always been effective. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014: Good governance.

The service was not always safe, the building was poorly maintained and health and safety checks had not been carried out as they should have been, meaning that some safety certificates had been allowed to lapse. Arrangements have been put in place to ensure this is rectified as soon as possible. This was a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014: Premises and equipment.

Mainly because of the poor maintenance of the building and some of the equipment, there were some infection control issues that needed attention. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014: Safe care and treatment.

People did not always receive person centred care. People's individual needs were not always identified. People's privacy was not always respected. Personal information was not always stored securely and staff discussed people's personal needs within hearing of other people. This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014: Dignity and respect.

People told us that they enjoyed their food; it was well cooked and plentiful. However, their mealtime experience would have benefited from staff being more attentive and concentrating on supporting people to eat their meals without talking over people to other staff members. This is an area requiring improvement.

Not all the staff were sufficiently trained to support people and keep them safe. There was a low percentage of staff training in some areas and some essential training had not been put in place. This is an area requiring improvement.

People were not always supported by staff who were kind and caring towards people and upheld their privacy and dignity at all times. We saw some examples of poor practice in this area. This is an area requiring improvement.

Staff were trained in adult safeguarding procedures and knew what to do if they considered people were at risk of harm or if they needed to report any suspected abuse.

Some systems were in place to identify risks and protect people from harm. Care records contained guidance and information to staff on how to support people safely and mitigate risks. Risk assessments were in place and reviewed monthly. Where someone was identified as being at risk, actions were identified on how to reduce the risk and referrals were made to health professionals as required. Records were detailed and referred to actions taken following accidents and incidents.

There were sufficient numbers of staff to meet people's needs. Staff recruitment procedures ensured only those staff suitable to work in a care setting were employed. Newly appointed staff received an induction to prepare them for their work.

Policies and procedures were in place to ensure the safe ordering, administration, storage and disposal of medicines. Medicines were managed, stored, given to people as prescribed and disposed of safely.

People's capacity to consent to care was properly considered and the home worked in accordance with current legislation relating to the Mental Capacity Act 2005 and the Deprivation of Liberties Safeguards. This included training for all staff on both subjects. Throughout our inspection, we saw that people who used the service were able to express their views and make decisions about their care and support. We observed staff seeking consent to help people with their needs.

People's health care needs were assessed, monitored and recorded. Referrals for assessment and treatment were made when needed and people received regular health checks. People's rooms were decorated in line with their personal preferences.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

The building was poorly maintained and health and safety checks had not been carried out as they should have been. There were infection control issues that needed attention.

Staff were trained in adult safeguarding procedures. There were sufficient numbers of staff to meet people's needs.

Medicines were managed properly and people received their medicines as they should.

Is the service effective?

Requires Improvement

The service was not always effective.

People's mealtime experience would have benefited from staff being more attentive. Not all the staff were sufficiently trained to support people and keep them safe.

People were supported to maintain their health and they received medical attention when it was needed.

People's capacity to consent to care was properly considered and the home worked in accordance with current legislation.

Is the service caring?

Requires Improvement

The service was not always caring.

People were not always supported by staff who were kind and caring towards them and upheld their privacy and dignity at all times.

Is the service responsive?

Requires Improvement

The service is not always responsive.

People did not always receive person centred care.

People were provided with the opportunity to participate in

meaningful activities. There was a system in place to manage people's complaints.

Is the service well-led?

Requires Improvement

The service was not always well-led

The quality assurance systems were in place but were not identifying areas of concern that were identified during this inspection.

Oakwood House Residential and Nursing 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 checked 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 8 and 10 November 2017. This inspection visit was unannounced. It was completed by one inspector and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. Our expert by experience gained their experience by caring for their parent while they were living with dementia.

Before our inspection, we reviewed all the information we held about the service. This included information about events taking place within the service and which the registered manager has to tell us about by law.

During our inspection, we spoke with four members of the care team, the registered manager, operations manager, deputy manager, the training manager and the administrator. We also spoke with 10 people who used the service. We observed and listened to how staff interacted with people. We also 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 care records for five people. This included assessments of their needs and risks, for example associated with mobility and falls. We checked how people's medicines were managed.

We examined four staff recruitment files, training records for the staff team, minutes from staff meetings and

the supervision and appraisal schedule for staff. We checked a sample of records relating to the maintenance of the premises and equipment. We inspected a selection of information relating to the quality and safety of the service. This included audits completed by the management team and the provider's representatives and the minutes of meetings with relatives and people using the service.

After our inspection visit, we asked other professionals who had been involved with the service and the people who lived there to share their opinions of the quality of care people received. Two professionals shared their opinions.

Requires Improvement

Is the service safe?

Our findings

The building was not safely maintained. During our inspection we inspected the health and safety files to establish whether systems were in place to maintain the safety of the environment. The health and safety files were disorganised and it took some time for files to be located. The gas safety certificate was out of date as the gas system had not been checked since July 2016. The engineer had recorded that one of the services' two boilers had failed the safety check, as it was not up to the current standards. The area manager was unable to tell us what action had been taken to get the boiler repaired, but confirmed it was still out of action. They reassured us that the service had two boilers and the hot water and heating had not been affected, the one out of action was the backup boiler.

When asked the nominated individual told us that the electrical hard wiring check was done in December 2012, which meant that another one was due in December. However, the engineer's report that was on file in the service was dated 18 April 2012 and the nominated individual could not provide us with any other evidence that there was a certificate issued in December 2012 as stated.

The registered manager nor the regional manager were unable to tell us if three potentially dangerous defects that were identified on the 2012 engineer's report had had been rectified within the five years since the safety inspection. The nominated individual told us that they had arranged for the work to be done.

We also noted that the annual fire safety equipment checks were four months out of date. This meant that people could not be assured that the building was safe and well maintained.

The building's maintenance was poor. Bedrooms were decorated as they became vacant, and the carpets had recently been deep cleaned. However, the décor overall was dull and battered with chipped and scratched paintwork. There were areas where the woodwork on the window frames was rotten and flaking. Tiles in some people's en-suite bathrooms had fallen off the walls and in one, there was a tile over the sink that was becoming detached and was in danger of falling off, possibly causing damage to the sink or hurting the room's occupant or a staff member.

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

Regular health and safety audits, such as fire alarm checks, emergency lighting and portable appliance testing (PAT), were taking place.

These examples of action not being taken to rectify identified faults indicated that the service does not have effective arrangements in place to respond external safety alerts.

Since our inspection, arrangements had been made for the boiler to be repaired or replaced and for a new gas safety certificate to be obtained. Arrangements were made for the fire safety equipment to be serviced and for the remedial electrical work to be completed so that the hard wiring checks could be carried out.

Infection control standards were not sufficient to protect people from infection. The service was generally clean but there was an underlying unpleasant odour in some areas of the service. We saw that pressure relieving cushions and mattresses had not been checked effectively and were stained and smelt very unpleasant. The registered manager showed us their monthly mattress check sheet. All the mattresses were marked as being acceptable and the cushions had not been checked. We unzipped a sample of the mattress covers and showed the registered manager the dirty mattresses. They agreed that they needed changing.

The infection control folder did not contain protocols in regards to safely dealing with bodily fluid spillages and we witnessed poor practice in this area. One person had been unwell and the spillage was dealt with in a way that did not conform to Department of Health best practice. The person's clothing was not changed, staff were slow to react and used paper towels to clean up the spillage, but put them in the general waste bin after use and did not use a chlorine-releasing agent to clean the floor.

The food trollies, used to transport meals to the dining rooms and keep the food warm could not be hygienically maintained because rusted areas did not allow for them to be cleaned properly to ensure they were free from infection.

The same applied to several of the stand aids and handgrips in people's en-suite bathrooms and some of the communal bathrooms. They were rusty so could not be effectively cleaned and kept free from infection.

Some armchairs and other soft furniture in the service had places that were worn and covers were split. Some seats did not have cushion covers, meaning that people sat on the foam interiors. They could not be cleaned sufficiently well enough to remove dirt and keep them infection free. This was unhygienic.

Fridges in the satellite kitchens on the three units all contained opened sauces, jams and sandwich fillers that had not been dated when opened. This meant that people could not be confident that they were safe to use because they might have been left in the fridge past their recommended use by date. There was also food that was covered, but not dated, and could be a possible source of food poisoning.

Some of the taps throughout the service had lime scale deposits, which is an area that can harbour legionella disease and allow it to develop and spread to other areas. Records showed that other legionella checks were carried out routinely.

This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014.

People's opinions of whether they felt safe were mixed. One person told us, "One of the [people] here walks about in [their] underwear…. People are always coming into my room… it's not good living here." Another person said, "I don't feel my life is threatened but I do feel I could be physically hurt (by other people living here)." And another, "If I need [the staff] they are there, I'm safe."

When we talked with the registered manager about the person who felt unsafe, they explained that the service supported people that had complex needs, everyone who lived in the service was living with dementia or had mental health issues. Some people who used the service were living with anxiety and distress and displayed this by presenting with behaviours that challenge. Sometimes people accused others of hurting them, there were recorded incidents of exchanges between people living at the service. One person had been given notice to leave the service because the person's mental health had deteriorated and the staff could no longer meet their needs.

People's care plans contained guidance for staff on how to help people better manage their behaviours, for example by distracting the person to help them focus on thoughts that are more positive. Staff were aware of people's needs, knew how to keep people safe and protect them from harm. Staff were able to tell us what they would do if they suspected or witnessed abuse and knew how to report issues both within the company and to external agencies. They had received training to be able to identify how people may be at risk of harm or abuse and what they could do to protect them. They were aware of the organisation's safeguarding and 'whistle-blowing' policies that were exhibited appropriately within the service. When concerns were raised, the registered manager had notified the local safeguarding authority in line with their policies and procedures and these had been fully investigated.

Risks to people's personal health, wellbeing and safety had been assessed. Staff had knowledge of risks and demonstrated they understood how to keep people safe from the risk of avoidable harm. Risk assessments were tailored to people's individual needs. They detailed what people and staff needed to do to ensure people received safe care. Risk assessments were reviewed regularly and updated to ensure staff had up to date information to keep people safe.

Risks to be people had been assessed, steps had been put in place to safeguard people from harm without restricting their independence unnecessarily. This meant that a variety of areas such as moving and handling, pressure care, eating and drinking and mobility were assessed. For example, encouraging people to wear suitable shoes to help prevent falls. This helped people to remain independent and meant they could continue to make decisions and choices for themselves.

Records showed us that people who had been assessed as being at risk of not getting enough to eat to keep themselves healthy, were receiving the care they needed to prevent deterioration and to eat a healthy diet.

People and staff told us that they believed there were enough staff working at the service. One staff member told us, "There are enough of us [staff], there are busy times but we manage." When asked if they get support from staff when they need it one person told us, "[The staff] come quickly, the night staff are good too." Another person said, "There is about the same [staff] at weekends. There is really enough staff all the time." The registered manager calculated how many staff were required to support people by using a recognised dependency tool. The rotas were planned well in advance and on examination, showed the staffing levels reflected what we had seen on the day of our inspection and what we had been told about the planned staffing levels.

Staff employed at the service had been through a thorough recruitment process before they started work. Permanent and agency staff had checks in place from the Disclosure and Barring Service to establish if they had any criminal record which would exclude them from working with people in this type of care service. All appropriate checks of permanent and agency staff had taken place before staff were employed to work at the service.

Medicines were safely managed. One person told us, "I have Parkinson's, they have a buzzer that lets them know when my medication is due." The dispensing pharmacist carried out regular audits of the way the service managed, recorded and dispensed people's medicines. When asked their opinion of what they found during their last audit the pharmacist told us, "I have found the team at Oakwood very helpful and knowledgeable with regard to management of medication historically. Where feedback has been given this has been welcomed and acted upon. I have observed interactions between staff members and the people they support whilst visiting and found them to be caring in their approach and knowledgeable regarding individual needs."

Staff had undergone regular training in relation to the management of medicines with their competencies checked. Storage was secure and balance checks on stock medicines matched records which showed that they were well managed. Records were comprehensive and well kept. Staff were observed giving people sufficient time to take their medicines and ensured that they had taken them before moving on to the next person. Staff told us they were confident that people received their medicines as they were intended.

Requires Improvement

Is the service effective?

Our findings

Staff told us that they had the training and support they needed to carry out their role effectively, training records supported these comments in most areas. One person told us, "I think [the staff] know what they're doing. They help me get what I need." A staff member said, "The training is good, I know what I need to do my job."

Staff received an induction into the service when they first started providing care and support to people. This included relevant training which included moving and handling and safeguarding. New staff also undertook the Care Certificate or other relevant qualifications. The Care Certificate is an industry recognised certification that covers all of the competencies that should be covered as part of induction training for new care workers.

The training manager carried out three monthly training audits, the last one was dated 31 October 2017. It showed that, on the whole, staff had received the training they needed to carry out their roles. However, the latest audit did show that there were some training courses that had not met their target completion percentage. For example, only 39% of staff had completed training for understanding fluids and nutrition needs, 54% of staff had completed the person centred care training and 65% of staff had undertaken the dignity in care training. Fire safety training showed that only 46% of the staff had completed this. The training manager explained that this shortfall had been identified during a recent audit and the training was planned so that staff could catch up in this area. The training manger had identified the training needed and was in the process of arranging for staff to attend the relevant courses.

Staff did not have training to enable them to understand and know how to support people with mental health needs. Also an historically identified need for care staff to undergo specialist training in the management of aggression to enable staff to better understand safe and effective physical interventions to manage the more challenging and aggressive behaviour, had not been fulfilled. The training manager had taken the 'train the trainer' training so they were in a position to offer it to staff. There had been logistical difficulties in rolling it out, the training manager acknowledged they needed to make it available to staff and had plans to do so.

The majority of the people who lived at the service were living with complex mental health needs that meant that they displayed their distressed feelings through behaviours that challenged and would have benefited from the staff having this training.

Although staff told us that the registered manager was approachable and made themselves available if they needed to talk with them, staff gave us differing opinions as to whether they received supervision with their line manager. Some told us they received appropriate supervision and appraisal, one told us they had not received supervision and another said they had it occasionally. Staff receiving supervision helped them to focus around developing their skills and knowledge and would have the opportunity to request training and discuss career progression. The manager acknowledged that the supervision programme had slipped and undertook to make sure staff received supervision more regularly.

The registered manager or a senior staff member carried out an assessment of the person's physical, mental health, and their social needs before a person began receiving care and support from Oakwood House. This information was used to develop a care plan, which addressed these needs and wishes.

People told us they were happy with the food they were served. One person told us, "Food is all right, no grumbles, there is a choice but not a wide variety." Another person said, "No criticism of the food, they make adjustments if there are things you don't like" One more person said, "It's okay, food is very good, they ask us what we want. The chef comes and asks us if the meal was alright and if there was anything we'd like for a change."

The service was split into three units, each with their own sitting cum dining areas. Some people chose to eat in their bedrooms. We observed mealtimes over all of the units. We saw that this time was not an enjoyable or pleasant experience for people. Very few people sat at the table to eat, most stayed in their easy chair.

Staff dished up people's meals without asking people what or how much they wanted, or if they had changed their mind since making their original choice earlier. Those people that needed assistance from staff, were given support, but the staff member went between people helping several at a time. One person was left having only eaten a small portion of their meal while the staff went to speak with another person who needed assistance. The staff did not return to the first person whose food was left to go cold next to them. There were enough staff on duty so people should have been getting the support they needed in a timely manner. Consideration should be given as to whether staff were being deployed effectively. There was little interaction between people and the staff. We saw that staff talked over people to talk with other staff members, when they talked about people and planned the rest of their shift.

The home had responded to specialist feedback given to them in regard to people's dietary needs and had taken action to meet them. For example, by introducing food that was fortified with cream and extra calories to enable people to maintain a healthy weight.

People were given the choice of what colour was used when their bedroom was decorated and we saw that their rooms had personal photographs and possessions, so that people could surround themselves with familiar ornaments to make their bedrooms feel more homely.

The hairdressing rooms were cluttered and untidy with inappropriate items such as wheelchairs, pads and staff walkie talkies. This did not make the area an attractive, homelike or comfortable area for people to use.

Wheelchairs and other moving and handling equipment were stored in corridors and bathrooms because there was little storage space in the service. This meant that these areas were crowded and contained possible trip hazards. Other rooms were used to store equipment and documents. One sitting room had a mattress stored behind a sofa and the hairdressing room contained a photocopier, filing cabinets and other office equipment. Communal rooms that were also used for storage meant that the service did not have a homely atmosphere.

There were very few photographs and pictures on the wall or objects of interest around the service. The manager told us that the people who used the service took pictures down and left them in areas that led to them being mislaid. We discussed with the registered manager possible ways that objects could be displayed that would ensure they could not be removed. They assured us that they would talk with their line manager and the provider to explore ways that storage within the service could be improved and ask the

maintenance person to find ways to be able to display photographs and pictures safely within the service to make the home feel more homelike.

The television digital reception was poor, meaning that people were unable to watch television, either in their bedrooms or in communal areas. This meant that people were not able to watch their favourite programmes. People either did not watch the television or watched DVDs. The signal had been bad for several weeks. The registered manager had been asked by the provider to get quotes for getting the system repaired, but the engineer who came in to look at the system could not identify the cause of the fault and the problem persisted without any indication of whether the system would be repaired. The registered manager assured us that they were trying to find an alternative system so that people could have their televisions working again. People told us that they missed having access to the television and had not been kept up to date about when it would be mended. One person told us, "I want to watch my programmes, when I try the picture is so bad I can't see anything and it hurts my eyes." Another person said, "The telly's been the same for eight weeks. You can't watch any programmes, it's terrible considering it's the main form of entertainment, we just grin and bear it…. It's just boring, I don't do the activities they are more for the older people."

The corridors were wide enough to enable people to use their walking aids and wheelchairs freely. The service had a built in hoist track in all the areas so that mobile hoists were not needed within the building and did not take up storage room, which was limited within the service.

The garden was well looked after and was a safe place for people to use. There was a circular path so people could have a walk around the garden without reaching a dead end, which led through an area lined with bushes to allow people the privacy to enjoy their walk. The registered manager told us that one person in particular liked spending time in the garden and they enjoyed walking between the bushes. To make sure they could do this safely the gardener was going to clear the stones and other trip hazards off the planted areas to lessen the risk of the person tripping while they were outside.

The service worked together with other professionals and services to deliver support and treatment. For example, they worked with the commissioning organisation when people were placed in their care. One professional told us that they had been working with the service and was meeting with the manager in the near future. They told us, "I am anticipating that they have made the changes to the [the work we were doing] by then." The service also cooperated with the speech and language team and dieticians and followed their advice when they supported people who were living in the service.

The service ensured that people were supported to maintain good health and sought professional advice when they needed it. One person told us that, "If I need a doctor, [the staff] arrange it. A doctor has been to see me this morning." Another person said, "Staff will see a doctor with me, then they can write it in my notes and help me to remember what [the doctor] said and explain it to me." Records demonstrated that the staff obtained advice or support from health professionals when they had concerns about a person's wellbeing.

People were asked for their consent before staff supported them with their needs. We observed throughout the day that people's consent was asked for before care and treatment was provided.

People who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the Mental Capacity Act (MCA). The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). People using the service had their capacity to make decisions and consent to their care

assessed appropriately under the MCA. DoLS applications had been made to the local authority and authorised where appropriate.

Staff were able to demonstrate they understood the MCA and DoLS and how this applied to the people they supported. Staff encouraged people to make decisions independently in areas where they were able. Staff demonstrated they knew people well, and this enabled them to support people to make decisions regardless of their method of communication.

Requires Improvement

Is the service caring?

Our findings

The registered manager and the staff's approach to treating people with kindness and compassion was mixed. On occasions, people's dignity and privacy were compromised.

We saw some examples of positive and caring interaction between the staff and people who used the service. One person told us, "It's alright, not bad at all, we've got good staff, can't complain about any of them." Another person said, "There can be a lot of laughter sometimes." We did see times when staff chatted with people, with light-hearted banter on both sides. Staff recognised when people needed support to understand where they were and why. We saw staff explain to one person why they were in the service when they asked to be helped to go home. The did it with tact and offered to make the person a cup of tea to redirect their attention so they could relax and settle down.

However, we also saw examples of uncaring attitudes. For example, staff used people's room numbers to refer to them instead of by their name. This was done by all levels of staff and sometimes in front of the people they were referring to. On occasion personal information was discussed in front of people. As in, 'Has [number] been done?' This practice was disrespectful and rude.

People did not get individual support during the mealtime. We saw staff supporting several people to eat at the same time, meaning that people did not get any meaningful interaction from staff during their meal. This practice also meant that people had to wait between mouthfuls and their food became cold, intimating that they were not important enough to the staff to care whether they got their food while it was still warm. Staff also talked to each other over people and to other people while they were supporting another person to eat.

Staff did not respond quickly to one person who had been sick and needed assistance, despite three members of staff being present at the time. They looked at each other and appeared reluctant to approach them. When the person was assisted it was not discreetly done.

A doctor visited the service during dinner; they were reviewing some people's medicines. Instead of being taken to an area that they could see people privately so they could be included in the discussion about their medicines, the doctor was taken into the dining room while dinner was being eaten and they were expected to do the reviews while people were eating.

People's private information was not always protected; care files were left out and open in the communal areas. If staff were working on them, they were left open on the table if they went to attend to someone who needed support. At other times, they were left on a shelf or on top of a cabinet. This meant that other people or visitors to the service could read them. Nor were they safe. There were people who lived in the service who collected paper that was left out and either threw it away or hid it. After we had discussed this with the registered manager, they found keys for cabinets where they could be stored securely. However, during our second day at the service we saw the care files were still being left on the table and had not been returned to the locked cabinet after use.

This represented a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014.

People were involved in making decisions about their care. They were invited with a family member to take part when their care plans were being reviewed. We saw that people had signed their care plans to say they have seen them and agreed with their content.

Information was posted in the service to advice people where they could get independent support and advice, form an advocacy service for example.

Requires Improvement

Is the service responsive?

Our findings

People's needs were assessed before they moved into the service to enable the service to decide whether they could meet their needs. If the person moving into the service was able to, they took part in the assessment to whatever level they were able. People's relatives and close friends were invited to contribute if the person was comfortable for them to be included. The service also sought advice and support from healthcare professionals both during people's assessments and afterwards to help achieve effective outcomes for them.

These assessments fed into people's care plans which identified how their care was planned for and provided. This included people's diverse needs and how these were met. The care plans mainly provided guidance for staff about how people's needs were to be met. However, we found that some improvements were required to ensure that people received responsive care at all times. The care plans contained essential information, but were not person centred and did not always contain people's life histories, past experiences, preferences and goals or how they would be reached.

People who had epilepsy, did not have an epilepsy risk assessment or a care plan that was individual to them. The records were generic and did not give staff information about the person's seizures, whether there were any triggers to the seizures, was the person given any warnings they were going to have a seizure or how they affected the person on recovery, for example.

The care plans were hand written on the provider's set format and, at times, were difficult to read.

The local authority provider support team was working with the manager to improve the quality of the care plans, after an audit carried out by the provider support team identified them as being of poor quality, with people's behaviours not being recorded positively. Also, they found that people's individual daily care notes contained poor terminology that was disrespectful towards some of the people who lived at the service.

The service supported people living with a wide range of complex needs. Everyone who lived in the service was living with dementia or had mental health issues. Some of the people who used the service were living with anxiety and distress and displayed this by presenting with behaviours that challenged the service. One person was unable to control their temper because of their mental health and sometimes hit out verbally and physically. Their care plan described their behaviours and how they could be supported at those times. However, it was not recognised that the person's personality was a symptom of their illness. The care plans were written in a way that reflected negatively on the person and intimated that they could control their behaviour. For example, in one document it was stated that they, 'had problems with [their] behaviour [they were] rude [and] nasty to staff.'

It was evident from the way staff reacted and spoke about the person that they did not recognise this either. This emphasised the need for the staff to be trained to recognise and understand how to support people with mental health needs.

Until recently, the service had one activities coordinator but this had now been increased to two staff who supported people with social activities. People told us that there were social events that they could participate in. One person told us that, "I stay in my room most of the time, listen to CDs, it's not bad living here. They take us out, I'm going out tomorrow to the pub, you can have a pint and fish and chips." Another person said, "I go out for a walk if it's a nice day, I'm not friendly with anyone here. But there is a lot on, I did a painting of a poppy yesterday, we had a service by the British legion, I have been to the Farmhouse Pub and I get books from the library."

The service used motion sensors to alert staff if people, assessed as being at risk of falling, get out of bed or stand up. This allowed staff to go and assist them to keep them safe.

We noted that a call bell was placed in one of the lounges, which when it sounded, was loud enough to interrupt conversation and people being able to listen to the television, which it was placed over. The registered manager later got in touch with the manufacturer and arranged to have the volume reduced. They also used the opportunity to investigate the possibility of having the volume of the call system being automatically reduced at night-time.

People told us that they could have visitors when they wanted them and relatives confirmed that there were no time restrictions on when they visited their family members. We saw people entertaining their visitors. This reduced the risks of people becoming lonely and isolated.

People told us that they were confident that if they made a complaint the registered manager would take it seriously and deal with it.

There was a complaints procedure which advised people and visitors how they could make a complaint and how this would be managed. One person said, "There are some people that complain all the time, I don't. I haven't had much to complain about, when I have the [staff] see to it straight away. "

People's complaints were investigated and responded to in line with the provider's complaints procedure. Complaints had been used to improve the service and experiences of people. This included guidance to staff on how to support people with their personal care needs and staff were reminded about the process of informing relatives about any changes in people's wellbeing.

People's end of life preferences and choices were not always recorded in their care plans. The registered manager assured us this was because they chose not to share this information with the service. Where people were at the end of their life there were systems in place to support people to have a comfortable, dignified and pain free death. Where people had chosen to discuss it, their records detailed their end of life wishes.

The manager told us that they worked closely with a local hospice and charity organisation when offering people end of life care.

Training was available for staff in end of life care. At the time of our inspection there was a low percentage of staff who had undertaken the training. The training schedule indicated that the next training date for this subject was planned for November 2017. The training manager confirmed that they expected a good turnout for the course.

Requires Improvement

Is the service well-led?

Our findings

Quality assurance systems were in place to regularly review the quality of the service that was provided. There was an audit schedule for aspects of care such as care plans and infection control. This would have allowed the registered manager to identify any concerns or possible risks to the service provided to people. However, since becoming the manager in December 2016 and then the registered manager in June 2017, they had not been fully supported to gain the knowledge necessary for them to effectively manage and monitor the service.

The regional manager was still the registered manager of another of the provider's care homes, so was therefore doing two jobs and was expected to continue until a new manager was appointed to take their place. This meant that they could not properly be available to support the new manager to become accustomed to their role and responsibilities.

Quality assurance audits were carried out but were often perfunctory and were not followed through. Therefore, they were ineffective and not fit for purpose. For example, the mattress audits were carried out regularly but were ticked as good, indicating they were clean and undamaged, in reality they were neither.

The concerns that we had identified during our inspection had not been identified, or if they had been identified, they were not dealt with effectively. For example, the electrical hard wiring check carried out on 18 April 2012 identified that there were three defects that were classed as potentially dangerous. The remedial work had not been carried out, although the need to have the work done was highlighted at one of the registered manager's support meetings.

Plans to carry out the outstanding safety checks identified during this inspection were put in place while we were still at the service. The provider has assured us the work will be done and has undertaken to inform us when the work is completed.

The governance framework was not clearly defined to ensure that everyone knew their responsibilities. The provider told us that it was the registered manager's responsibility to ensure the audits were done and up to date and that the health and safety checks and servicing was done. However, it is the registered provider's responsibility to ensure that the registered manager is properly monitored, supported and able to carry out their duties.

It was not evident that the management team were aware of the day-to-day culture of the service or that they promoted a positive culture that is person centred. As evidenced in this report, people's right to privacy, dignity or respect was not always championed by the service. The management team had not recognised the seemingly uncaring attitude that some staff had when supporting people with their day-to-day care needs, with eating their meals for example. Nor were staff stopped from referring to people by their room numbers instead of their names, staff at all levels used this practice.

Staff told us that they felt demoralised, they did not feel they were included in developing the future of the

service.

This represented a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014.

People who lived in the service told us that the registered manager listened to them and was approachable if they had concerns to raise. One person told us, "I can have a chat and a laugh with [the registered manager]. I see them about the place and they often stop for a chat." Staff told us that they found the registered manager easy to approach and was available if they wanted advice or assistance. One staff member told us, "The office door is always open and I'm not shy in coming forward."

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The provider failed to ensure that people using the service were cared for in a way that respected their rights to privacy, respect and dignity.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to ensure that infection control measures were properly carried out.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The provider failed to ensure that essential health and safety checks were completed.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to ensure that was a robust quality assurance system in place that enabled them to identify areas that need improvement. They failed to take action when areas of concern were identified.