Inspection Report

We are the regulator: *Our job is to check whether hospitals, care homes and care services are meeting essential standards.*

Oaktree Care Home

Lark Rise, Brimsham Park, Yate, Bristol, BS37 7PJ

Tel: 01454324141

Date of Inspections: 19 May 2014
15 May 2014
14 May 2014

Date of Publication: July 2014

We inspected the following standards in response to concerns that standards weren't being met. This is what we found:

Respecting and involving people who use services	✖ Action needed
Care and welfare of people who use services	✖ Action needed
Meeting nutritional needs	✖ Action needed
Cleanliness and infection control	✖ Action needed
Safety and suitability of premises	✖ Action needed
Staffing	✖ Action needed
Assessing and monitoring the quality of service provision	✖ Action needed

Details about this location

Registered Provider	Laudcare Limited
Registered Manager	Mrs Cathryn Elizabeth Shipsides
Overview of the service	Oaktree Care Home can accommodate up to 78 people.
Type of services	Care home service with nursing Care home service without nursing
Regulated activities	Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury

Contents

When you read this report, you may find it useful to read the sections towards the back called 'About CQC inspections' and 'How we define our judgements'.

Summary of this inspection

Why we carried out this inspection

We carried out this inspection in response to concerns that one or more of the essential standards of quality and safety were not being met.

This was an unannounced inspection.

How we carried out this inspection

We looked at the personal care or treatment records of people who use the service, carried out a visit on 14 May 2014, 15 May 2014 and 19 May 2014, observed how people were being cared for and checked how people were cared for at each stage of their treatment and care. We talked with people who use the service, talked with carers and / or family members, talked with staff and reviewed information given to us by the provider.

What people told us and what we found

The purpose of this inspection was to find out five key questions. Is the service caring? Is the service responsive? Is the service safe? Is the service effective? Is the service well led?

Below is a summary of what we found. The summary is based on our observations during the inspection, seeking experience and views from people who used the service, their relatives, and the staff supporting them and from looking at records.

If you want to see the evidence supporting our summary please read the full report.

Is the service caring?

We found that staff we saw treated people kindly but people did not receive care in a way that respected their dignity and independence.

One person who lived in the home told us, "Some staff just complete tasks; they go through the motions or not as the case maybe. I think this is attributed to a lack of knowledge, education and that there is not enough staff". One staff member told us, "I wish I could say care was individualised but we just don't have the time. We do as much as we can but I have to admit we are only able to provide the basics". We saw that staff were rushed throughout the day.

People's personal care needs were not respected and their dignity was compromised, for example people had not been assisted to wash and dress as they would wish or helped to eat their meals. We saw people with food left in their laps following mealtimes; clothes were not always protected from spillages from food and drink.

People were not cared for in a home that was safe and clean, with poor hygiene standards throughout the home. The premises, décor and soft furnishings were tired and in need of replacement and repair.

Is the service responsive?

We saw that appropriate referrals were made to health and social care professionals. Staff had identified risks to people and how this would be managed. This included people that had swallowing difficulties and were at risk of choking.

People had been assessed by their GP and the speech and language therapists and staff were following the guidance so that people were supported appropriately and safely in order to minimise the risks.

Is the service safe?

People were not protected from the risks of inadequate nutrition and dehydration. This was because people were not helped at mealtimes so that they received sufficient amounts of the food and drink that was provided to them.

Because there were discrepancies around accurate recording in people's charts staff and people using the service could not be assured that food and drink intake monitoring was effective. This meant that staff may not be aware that people were at risk of poor nutrition and hydration and take any necessary action.

The service was not clean and hygienic. Appropriate guidance, equipment and facilities were not in place. This meant that people who used the service were not safe or protected from the risks associated with cross infection.

People did not live in surroundings that were safe and promoted their wellbeing. We found that equipment provided to people was unsafe and not properly maintained.

The home had less staff on duty than the manager had determined were needed to meet people's needs. Additional cover was not provided when there was any staff absence. Staffing levels did not take into account unforeseen circumstances or emergencies.

Relatives had expressed concerns about access to staff at weekends, they questioned the staffing levels in the home and they were concerned about how long people's call bells rang before they were answered.

Is the service effective?

Some care plans only contained basic information and guidance about the care and support people required. They did not show that people had been involved in developing their own care plans so that the staff could provide them with personalised care.

We spoke with two relatives who were visiting two people living with dementia. They told us, "I have not been asked to be involved in care plans I don't know what they are" and "It was mentioned at the relatives meeting in April that we could be involved in care plans but I haven't heard anything since then".

People were not supported to be independent at mealtimes because they were not provided with the appropriate equipment to help them to eat.

The needs of people living with dementia had not been considered with regards to their environment. There were no signs that would help people move around independently. Equipment was stored in en suites and in communal bathrooms and toilet facilities. This

meant that people could not move around freely and safely.

Is the service well-led?

We found not all aspects of the service were well-led

The home did not have a registered manager, although an application to register had been made. The management arrangements did not provide strong leadership as action had not been taken to improve the care or environment in the home. We found that the quality monitoring systems in place were not effective and had not identified improvements where needed.

This included the homes environmental audit which had failed to identify the serious concerns we found during our visits regarding the quality and safety of the environment. The audits did not identify risks to people who used the service in order to keep them safe from harm.

You can see our judgements on the front page of this report.

What we have told the provider to do

We have asked the provider to send us a report by 16 July 2014, setting out the action they will take to meet the standards. We will check to make sure that this action is taken.

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

Where providers are not meeting essential standards, we have a range of enforcement powers we can use to protect the health, safety and welfare of people who use this service (and others, where appropriate). When we propose to take enforcement action, our decision is open to challenge by the provider through a variety of internal and external appeal processes. We will publish a further report on any action we take.

More information about the provider

Please see our website www.cqc.org.uk for more information, including our most recent judgements against the essential standards. You can contact us using the telephone number on the back of the report if you have additional questions.

There is a glossary at the back of this report which has definitions for words and phrases we use in the report.

Our judgements for each standard inspected

Respecting and involving people who use services ✖ Action needed

People should be treated with respect, involved in discussions about their care and treatment and able to influence how the service is run

Our judgement

The provider was not meeting this standard.

People's privacy, dignity, and independence was not always respected. People's views and experiences were not taken into account in the way the service was provided and delivered in relation to their care.

We have judged that this has a moderate impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

Reasons for our judgement

We saw examples throughout our visits to the home, where people were not treated with dignity and respect.

We saw people with food left in their laps following mealtimes; clothes were not always protected from spillages from food and drink and people's clothes were left soiled. We saw food had been left on people's hands and faces and had become encrusted over a length of time.

People had not been appropriately helped to maintain their personal appearance and their dignity was compromised. This was because the majority of people looked unkempt, some people we sat and spoke with had an unpleasant odour, they had dirty teeth and their hair was visibly dirty.

When we observed mealtimes we saw staff standing over people when they were supporting them with their meal. These people were unable to eat independently and needed assistance. Staff did not sit at the same level as them and there was little or no conversation or prompting throughout the meal. This demonstrated a failure to ensure that people's independence was promoted and supported so that mealtimes were an enjoyable experience.

People were not treated with consideration and respect as they did not live in an environment that promoted their dignity. There were significant poor areas of hygiene throughout the home and the premises, décor and soft furnishings were tired and in need of replacement and repair. An example of this included, bedding that was torn and ripped and towels were threadbare and frayed.

We saw examples throughout our visit where people's rights, choices and preferences were not sought or respected. On the second day of our visit we saw a member of staff in the area of the home supporting people with dementia serving food from a hot trolley at lunchtime. Having watched them serve four dinner plates of either a brunch or roast we asked them how they knew what people had chosen. This was because we could not see a list that would indicate that people had been asked what they wanted for their meal and the staff did not offer a choice as they were serving the meal. The staff member told us that they did not use a use a list and that they knew people well enough to know what they liked and disliked.

Two hours later we went to a person's room where we found they had a plate of the brunch option, it was cold and untouched. The pudding had also been served and was untouched. We asked the person why they hadn't eaten their meal. They told us that they didn't like tomatoes. The brunch included a portion of canned tomatoes and the meal was covered in the tomato juice.

One person who was having lunch in their room was approached by a member of staff. They asked the person if they wanted flan or ice-cream for pudding. We saw that the person was trying hard to interpret this question and digest the information but they found it difficult to verbalise this. The home did not use any pictorial or other support to help people make choices where they had communication or comprehension difficulties. After a few minutes of silence the staff member told the person they would get them some ice cream.

In the large dining room upstairs we saw that people were offered no choice with regards to a pudding. A portion of flan was placed in front of all 17 people. Fifteen minutes later ice cream was brought up from the kitchen. Those people who had not touched the flan had it removed and were served ice cream but they were not consulted about this.

Care and welfare of people who use services ✖ Action needed

People should get safe and appropriate care that meets their needs and supports their rights

Our judgement

The provider was not meeting this standard.

People did not experience care, treatment and support that met their needs and protected their rights.

We have judged that this has a minor impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

Reasons for our judgement

We spoke with 15 staff over the course of three days. We asked them to share their views and experiences with us about peoples' care and welfare. We wanted to see what was in place to ensure that people were protected against the risks of receiving care that was inappropriate or unsafe.

Staff told us that they were 'frustrated and concerned'. Comments included, "I don't feel equipped with the right skills, I have never had dementia training so I would say I am self-taught", "We truly do the best that we can, I don't cut corners or rush people but it does mean that I am always behind and the next person or job has to wait", "I wish I could spend more time talking to people" and "We do have some people with dementia that get very distressed and need support. I have not had training on how to help people when they are like this, I have been told to make sure they are safe and walk away. This never seems enough and I do try to reassure them".

We looked at the homes 'Person centred Planning Policy'. It stated "The company recognises that person centred care is not just about providing individualised care. It is an approach used to recognise the uniqueness of each person, to value their contribution to care and to provide care that is centred on the person rather than the company".

Staff told us that people had high dependency levels in aspects such as personal care, continence care, moving and handling, nutrition and hydration needs and emotional and psychological needs. We asked staff if they felt that the care people received was person centred. Comments included, "I wish I could say care was individualised but we just don't have the time", "We do as much as we can but I have to admit we are only able to provide the basics" and "It can't be person centred because there isn't enough time and this has meant that staff are picking up bad habits".

We asked this member of staff what they meant by 'bad habits'. They told us that people were not receiving baths or showers because it "took too much time" and that staff were "not always using the correct moving and handling techniques because it took too long to

go and get the hoist". However we did not observe people being assisted to move without the use of the correct equipment.

On the second day of our visit we asked a member of staff why some people downstairs were in bed eating their lunch. They told us that it was "easier that way". During our visit we saw many people who had not been appropriately assisted to maintain their personal hygiene or appearance, where they needed help from staff to do this.

One person who lived in the home told us, "Some staff just complete tasks; they go through the motions or not as the case maybe. I think this is attributed to a lack of knowledge, education and that there is not enough staff". We spoke with three relatives during our visits. They told us, "I know the staff care about my relative and they want to do their best", "They contact me if my relative is ill and tell me that the GP has visited" and "I think they do their best but sometimes I feel disappointed when basic care is not given".

We looked at a monthly checklist that was completed in March 2014. The checklist required staff to review peoples' care plans monthly and if there was evidence that the resident, next of kin, or relative had been involved in developing the plans. We looked at the results for eight people that lived in the home. The checklist confirmed that this had not happened for all of these people.

When we looked at care plans we saw that some only contained basic information and guidance about the care and support people required. They did not evidence that people had been involved in developing care plans so that they contained people's personal preferences and preferred daily routines to inform staff about people's individual needs. One example was a personal care plan that we looked at. It didn't provide staff with detail about how much support they required, if they preferred a male or female member of staff, if they preferred to use specific toiletries and what they preferred to wear.

The monthly checklist also asked if 'preferences and wishes had been linked to people's needs and care plans'. The checklist recorded that this had not happened. One staff member told us "We are not up to date with care records and people and their families have not been involved when we develop care plans. We are not allocated protected time to complete this". We spoke with two relatives who were visiting two people with dementia. They told us, "I have not been asked to be involved in care plans I don't know what they are" and "It was mentioned at the relatives meeting in April that we could be involved in care plans but I haven't heard anything since then". We could not be assured that staff had clear, up to date information about how to care and support people so that it was effective and meaningful to them.

We did see evidence where staff had identified risks to people and how this would be managed. This included people that had swallowing difficulties and were at risk of choking and referrals had been made. People had been assessed by GPs and the speech and language therapists. Assessments that had been completed and gave staff clear instructions and guidance on the required consistency of food and how much thickening agent should be used in drinks and soups. We spoke with staff who confirmed that the correct amounts were being used. We looked at stock of the thickening agent that was dispensed by pharmacy every month. The amount of stock evidenced that the thickening agent was being used as prescribed. We also saw drinks that contained the thickening agent.

Meeting nutritional needs ✖ Action needed

Food and drink should meet people's individual dietary needs

Our judgement

The provider was not meeting this standard.

People were not protected from the risks of inadequate nutrition and dehydration.

We have judged that this has a moderate impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

Reasons for our judgement

We identified concerns at mealtimes during the inspection and looked at how the home supported people so that they received adequate food and hydration. We looked at the weights recorded for those people who had dementia. In total we saw that 24 people had lost significant weight between the months of December 2013-April 2014. The highest weight loss recorded for one person was 8.2kgs. Sixteen people had lost between 2.5kg and 8kg. Some people had lost a significant amount of weight in short period of time. One person had lost 6.5kgs between December 2013 and January 2014. Two people had lost 5.2kgs between January and February 2014.

One of our concerns was that people were not supported effectively at mealtimes. We found that people did not have necessary equipment available to enable people to eat as independently as possible.

We observed people that were unable to use a knife and fork and so they used a spoon. They did not have plate guards which meant that the food was sliding off the plates. Pudding bowls we saw were too deep for people to use, they were made of a lightweight plastic and when people tried to scoop food out of them, the bowls kept moving around the table. People did not have slip mats to help prevent this from happening.

We sat with one person in their room whilst they were eating their pudding. They were trying to scoop ice cream from their bowl. They were only able to use one hand. The bowl fell into their lap and we helped put it back on the table. Because they could not use the utensils they started to eat the ice cream with their fingers .We did not see a member of staff check on this person to ensure that they were eating their meal for the 15 minute duration we were with them.

This showed that people did not receive the necessary support to eat sufficient amounts of the food provided to them.

When we looked at the food and fluid intake charts for these people they had been filled in incorrectly. This was because staff had recorded how much food had been consumed by looking at what was left on people's plates and had not considered the food that had been

wasted through falling off the plates. We saw food in people's laps, on their tables and on the floor. When we looked at the chart for the person we assisted with their pudding the staff had recorded that they had eaten three quarters of their meal. However half of their meal would have been a more accurate record.

We saw two people had not eaten their meal. We saw staff remove their meals that had gone cold without offering an alternative. When we went back to check food and fluid charts for these two people. Staff had recorded that they had eaten half and three quarters of their meal but this was not the case.

At 1:30pm on the second day of our visit we looked at five people's nutrition and fluid charts. The charts did not have any entries recorded for seven hours. At 2pm which was the end of the first shift one staff member had completed all five charts. They all recorded similar amounts of food and drink that people had apparently had. We were also told by the manager that one staff member had filled in a chart at lunch time indicating that a person had received staff attention at 4pm.

We spoke with staff and asked them about their views with regards to the accuracy of the fluid and nutrition charts. Comments included, "They are totally open to discretion and I cannot say truthfully that they are all accurate", "Time is so limited, you collect a plate and make a mental note of what has been eaten, then the call bell rings and you go to attend to another person, the list is endless with different scenarios and then at the end of the shift you realise you have not completed the charts", "The staff are always rushing around trying to look after people and sometimes it's hard to remember who had what" and "I think some staff use guess work when filling in the charts".

We saw that there were inconsistencies between staff when they recorded how much a person had had to drink. Staff were recording 150mls for a cup of tea and yet when we measured how much fluid a tea cup could hold the maximum was 120mls. Another commonly used receptacle was a yellow two handled beaker. This held a maximum amount of 200mls. Staff had recorded 200mls on people's charts, yet we saw numerous beakers of cold tea and coffee some of which had been untouched, throughout our visits. One staff member told us "I have no idea how much fluid each cup holds, again its guess work".

Fluid charts were 'signed off' by night staff at the end of their shift. However they did not total the amount of fluids that each person had over a 24 hour period. This meant that staff would not be alerted to a poor intake so that increased efforts could be made the following day and the risks of dehydration identified could be minimised.

Because of the discrepancies around accurate recording in people's charts staff and people using the service could not be assured that food and drink intake monitoring was effective. This meant that staff may not be aware that people were at risk of poor nutrition and hydration and take any necessary action.

We were told that night staff were responsible for making sure that people had a jug of water in their rooms each morning for the day ahead. Throughout our visits we saw that most people on the dementia floor still had jugs that had not been touched in their rooms. We did not see that any water intake had been recorded on people's charts. People were not offered a choice of squash in their jugs and for some people the jugs were too far away to reach.

A visiting healthcare professional that had visited two people with dementia to review their

care told us they had serious concerns about people's fluid and food intake. They told us that they could not be assured that people were not dehydrated. They told us about the fluid chart for one person, who had a catheter. It had been recorded that they had drank 1020mls of fluid over a 24 hour period but they had only passed 270mls of urine during this time. Staff had not been alerted to this poor output and the care records did not provide evidence to say what or if any action had been taken.

Cleanliness and infection control ✖ Action needed

People should be cared for in a clean environment and protected from the risk of infection

Our judgement

The provider was not meeting this standard.

People were not protected from the risk of cross infection because appropriate guidance had not been followed. People were not cared for in a clean, hygienic environment.

We have judged that this has a major impact on people who use the service. This is being followed up and we will report on any action when it is complete.

Reasons for our judgement

We had not planned to inspect this outcome as part of our inspection. However as we were shown around the home we saw evidence that many parts of the home were not clean. In some areas of the home the interiors fixtures, fittings and furnishings were not in good physical repair and could not be effectively cleaned.

The home had a strong and unpleasant odour throughout, however the odour on the floor for those people who had dementia was particularly overpowering. We identified pieces of furniture and equipment during our visits to the home that posed a risk to people and these were removed from home. This was because they were unsafe, could not be repaired and could not be cleaned to an appropriate standard to minimise risks of cross infection.

We spoke with housekeeping staff, nurses and care staff about the cleanliness of the home and why certain areas were particularly unclean. We also sought the views of people who lived there, relatives and visiting health and social care professionals. Comments included, "I have been visiting the home for a few years now, it's always had an unpleasant odour but never has it been this strong", "It's a large home to clean. Staff absence has had an impact on deep cleaning schedules", "I think it's about lack of reporting and there is not enough ancillary staff to deal with unforeseen accidents" and "It is shameful, I wouldn't want to live here".

People were placed at risk of cross infection as appropriate standards of cleanliness had not been maintained. We saw that commodes, toilet seat raisers and shower chairs were dirty and ingrained with dried urine and faeces, dust, dried talcum powder and rust. Plastic coating on the frames of these had started to peel away to expose rust. Two people's commodes which had exposed rust areas had been patched up with sticky tape and masking tape. This meant that the effective cleaning was compromised and these areas could harbour germs.

The homes wet/shower rooms were dirty. The shower screens, tiles and sealant were covered in, scum, lime scale, mould, rust and mildew, which had built over time. Toilet

pans were also stained. Tiles were broken and some had fallen off the wall and exposed plaster. This meant that cleaning could not be effective in these areas.

The furniture, fixtures and fittings and soft furnishings in people's bedrooms were dirty. We saw urine and faeces stains on divan beds, lounge chairs, bed rail protectors, and carpets. The rooms had been 'surfaced cleaned' but when we moved furniture in some of the rooms we found dust and food debris. We looked at cleaning schedules and spoke with staff. Both the records and staff confirmed that 'deep cleans' were not being carried out which also placed people at risk of acquiring infections.

Those people at risk of falling out of bed were on low profiling beds. Crash mats were on the floor by the side of people's beds to protect them if they slid out of bed. These were sticky with food and drink.

People's side tables were rusty; the laminate had peeled off to reveal rough chipboard. They were sticky with food and drink. One relative told us, "I don't understand why staff can't wipe the table clean after lunch when they take away the plates after each mealtime". During our visits we saw that staff had cleared away crockery and utensils for those people who had eaten in their rooms. We saw that people still had food on their table, on the floor and in their chairs and laps up to two hours after mealtimes had finished.

We pulled back the bedding of four beds and found that two beds had been remade with sheets that were stained with yellow and brown marks. A staff member confirmed that that these marks were urine and faeces and that staff were responsible for making beds. These mattresses smelt of urine. When we pulled back the bedding on one mattress we saw dry, flaky skin cells and dried spaghetti over it and in the crevices. We saw four wheelchairs that were also dusty and encrusted with food and drink.

Carpets throughout the home were stained with urine, food and drink spillages. We were told by the area manager that carpets had been ordered for 27 bedrooms.

The large lounge carpet upstairs was caked with dirt, food, urine and drink spillages. The pile on the carpet was minimal and beyond cleaning. There was a very strong smell of urine in this room. We pulled out the cushions of every lounge chair in this room. All the chairs had food debris and urine stains on them. There was also a small settee and we removed these cushions. The fabric was ingrained with urine and dried faeces and there was food debris.

We asked to see the most recent infection control audit and we were provided with a copy of an audit that had been completed in December 2013. The audit highlighted 'areas of non-compliance' throughout the report. The audit had not been fully completed. We saw that the audit requested 'target dates' for a review on 'non-compliance' and what 'action was taken with dates and evidence' had not been recorded.

It was evident from our findings during our visits that many of the concerns identified in the provider's audit of December 2013 had not been not been addressed and cleanliness had not improved. The report had identified non-compliance in people's bedrooms. It stated that they found "dust, crumbs and dirt behind the beds and armchairs, windows were dusty and there were cobwebs in the corners of the ceilings". It also stated that, "bathrooms have tiles missing; shower guards have lime scale and mildew deposits on them, and toilets are stained"

Safety and suitability of premises ✖ Action needed

People should be cared for in safe and accessible surroundings that support their health and welfare

Our judgement

The provider was not meeting this standard.

People who used the service, staff and visitors were not protected against the risks of unsafe or unsuitable premises.

We have judged that this has a moderate impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

Reasons for our judgement

We had not planned to inspect this outcome as part of our inspection. However in addition to the concerns we identified about the cleanliness of the home, people did not live in surroundings that were safe and promoted their wellbeing.

Oaktree is an established care home providing accommodation for 78 people. The home is on two floors with a lift servicing the second floor.

We asked people, relatives, staff and visiting health and social care professionals their views on the environment. Comments included, "It's all looking tired now and needs updating", "The home has had little investment in the environment, they do a little thing here or there, it's all lip service", "My relatives room is lovely but that's because we as a family have made it that way", "The lounge upstairs is an embarrassment and reflects how much people are valued by the people that own the home" and "The environment upstairs does not support people with dementia, they think naming the corridors, painting walls a different colour and sticking some shells on the wall is enough". One person wrote to us and said "Whilst the more able residents downstairs have had new carpets fitted, the rooms upstairs are sparse and unwelcoming".

Needs of people who had a diagnosis of dementia had not been considered with regards to the environment. Bathroom walls, bathroom suites, toilet seat lids, handrails and shower chairs were all white. This meant that there was no contrast of colours and they could not easily be identified as to their use. This would help people find their way around more independently. Published best practice guidance by the Social Care Institute for Excellence identifies the need for a suitably designed environment to help people maintain their dignity and independence.

The bathrooms and wet/shower rooms were clinical in appearance and did not create an atmosphere that was conducive to people that would find bathing an inviting, relaxing experience.

Throughout the home bathrooms were being used for storage. This included wheelchairs, hoists, linen trollies, and commodes. They were also cluttered with continence pads, washing up bowls, toilet seats, commode pans and walking aids and in some bathrooms this caused an obstruction to the toilet facilities. This meant that people were unable to use the toilet facilities safely. This had been recorded in the infection control policy of December 2013 which stated that 'cleaning could not be effective due to clutter'. There was no evidence that this had been addressed or improved.

One bathroom was out of use on the floor for those people with dementia because the toilet was not working. There was no sign on the bathroom door to inform people. There was a piece of paper on the toilet seat saying 'out of use'. The sign was not effective for those people with an impaired understanding and would not alert them that to use the toilet would be unsafe.

People had been supported to make their rooms personal. Some bedrooms had been decorated and refurbished to a suitable standard. The remaining bedrooms had not been redecorated for some time. Flooring, bedroom furniture and soft furnishings needed replacing. Curtains were missing curtain rings so they did not hang or close properly.

We found that equipment provided to people was unsafe and not properly maintained. People had small tables in their rooms, the majority of these were old and in a poor state of repair. The legs were rusty and the laminate had peeled off exposing rough wood. One person had a table that was broken and the top was only secured to two of the legs. We saw that every time the person moved their table the top swung off the two legs that it wasn't attached to and was balancing on the two remaining legs. When we saw this happen the person had a cup of tea on their table. This meant that the person was at risk of scalding. The table was removed from use on the day of our visit.

Bedroom furniture was not always big enough for people's belongings. We saw that drawers were so full of clothing items that when we tried to open the bottom drawer it opened all the other drawers above. This meant that the drawer unit was at risk of toppling over. We saw that en suite facilities and wardrobes were used for storing people's continence pads. Handles were broken and missing on some drawers. Some chairs were covered in a leatherette material and some areas were cracked and broken. The surface was rough and a potential risk to cause injury to fragile skin.

We went into one person's room and saw them in a low profile bed. The bed was lowered to the same level as the plug sockets. The person had complex dementia and was touching and pulling at the plugs, the plug sockets were hanging off the wall and the wires were exposed. When we pulled a bed away from the wall in another person's bedroom we saw a double wall socket and a telephone socket hanging off the wall. There were also exposed wires. We also saw that this person's call bell cord was detached from the call button and the wires were exposed. The deputy manager called an out of hours maintenance person and these were made safe that evening.

Staffing ✖ Action needed

There should be enough members of staff to keep people safe and meet their health and welfare needs

Our judgement

The provider was not meeting this standard.

The provider had not taken suitable steps to ensure there were enough qualified, skilled and experienced staff to meet people's needs.

We have judged that this has a moderate impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

Reasons for our judgement

We looked at this outcome in response to concerns raised during our inspection.

We looked at the provider's agreed staffing levels for the whole home over a 24 hour period. These were 12 care staff from 8am-2pm, 11 care staff from 2pm-8pm and seven care staff from 8pm-8am. Nurse cover was four nurses from 8am-2pm, three nurses from 2pm-8pm and two nurses from 8pm-8am. However at the time of our inspection we found that the numbers of care staff on duty were not maintained at this level.

We were told that the home was piloting a new tool that determined staffing levels in the home. The provider was still developing this tool because it didn't take into consideration certain factors. This included the layout of the home and accessibility of facilities and competencies and skill mix of staff. It also needed to take into account that people's needs were increasing requiring more staff support.

We could not judge the effectiveness of the existing tool because the home was not working to the levels that the tool had determined. We looked at the staff rotas for the week beginning 5 May 2014. In total 96 hours of care staff shifts were not covered. The week beginning 28 April 2014 showed that 112 care staff hours had not been covered. The staff rota for the week beginning 21 April 2014 also confirmed that 112 care staff hours had not been covered. This meant that the home had less staff on duty than the provider had determined were needed to meet people's needs.

We were told by the manager and area manager that there were staff vacancies and that staff had left and others had handed in their notice. Permanent staff were covering some shifts to maintain continuity and consistency of care. At the time of the inspection we were told there were 132 vacant hours for nurses, and 90 vacant care staff hours per week. The home was currently in the process of recruiting and interviews had been arranged.

We spoke with the manager and the area manager and asked them why these shifts had not been covered. The managers told us that they had been instructed that agency cover

could only be requested and approved for nursing shifts and not care staff. The area manager told us that this was not the provider's policy and that they would conduct an investigation as to why this had happened. Later that day we were told by the area manager that an agency had been contacted and that all vacant shifts were being covered.

The staffing levels did not take into account unforeseen circumstances or emergencies. This included which included increased dependency levels, where people needed a greater amount of care and support. On the second day of our visit two people who had dementia became very anxious and distraught. This was managed effectively and safely by two care staff who provided continuous one to one support. However this meant that there were only four care staff available to meet the needs of the remaining 39 people in this part of the home. This meant that there was a risk that people would not receive the care and support they needed at this time.

This subsequently had an impact on the lunch time that day. It was very busy and call bells were also ringing because people required assistance with other needs. The area manager also observed and provided assistance to people during this lunch time period as the staff on duty needed extra assistance. They agreed that this lunch time had not been satisfactory.

We were provided with a sheet that had highlighted those people who required the direct assistance of staff at mealtimes. We were told that 20 people who lived upstairs had been assessed as requiring either "full support or lots of support". This included one to one assistance throughout the meal, prompting, encouragement and physical help for example cutting up food. These people had dementia. We saw that not all of these people were being assisted and they were not eating their meal. We saw people sat with meals in front of them but they were not able to eat their meal without staff assistance. We saw two people get up and walk away from the table leaving their uneaten meals. There were no staff present to support them back to the table or to offer them assistance and encouragement to eat.

The area manager agreed that the daily routines could be more effective so that care and support was not compromised. They told us that previously the home had two sittings at mealtimes so that staff were able to provide more assistance to individuals. Nobody we spoke with knew why this routine had been changed.

Staff we spoke with raised concerns that there were not enough staff to support people safely. For example, some staff we spoke with were concerned about people's safety. They told us, "I worry about the residents, the other night I couldn't stop worrying that there was something I may have forgotten to do on my shift" and "There is an increased risk from 6pm particularly in the large communal lounge upstairs. Many of the residents start to become distressed and anxious around this time. Someone should be supervising them but the staff are all busy providing personal care, meeting continence needs and getting people ready for bed".

We looked at the minutes of a relatives meeting held in April 2014. Relatives had expressed concerns about access to management and staff at weekends, they questioned the staffing levels in the home and they were concerned about how long people's call bells rang before they were answered. One relative told us that they had "timed call bells on several occasions and that some could be ringing for up to 20 minutes".

We spoke with relatives and visiting health and social care professionals. They all told us

that they had concerns about the staffing levels. Comments included, "I worry about one person's safety because they cannot walk independently, I can spend 20 minutes trying to find a member of staff to come and help them", "It can take a while before I can find a member of staff to assist me with my visit" and "I have visited and left without seeing a member of staff".

Assessing and monitoring the quality of service provision ✖ Action needed

The service should have quality checking systems to manage risks and assure the health, welfare and safety of people who receive care

Our judgement

The provider was not meeting this standard.

The provider did not have effective system in place to identify, assess and manage risks to the health, safety and welfare of people using the service and others.

We have judged that this has a moderate impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

Reasons for our judgement

There was a management structure in the home but it did not provide people with clear lines of responsibility and accountability. People who used the service were not protected from the risks of inappropriate or unsafe care and treatment. This was because the systems to assess and monitor the quality of service were not effective. Risks relating to people's health, welfare and safety were not assessed effectively.

Evidence of breaches in regulations throughout the inspection demonstrated that there had been a failure to identify and manage risks for people across the home.

We looked at audits undertaken by the service that linked to the outcomes we inspected. We found that they were not effective and had not identified the shortfalls that we identified at this inspection. Prompt action was not always taken to address concerns.

We looked at the environmental audits that had been completed by an area manager. We looked at the audits for March and April 2014. We found that they had failed to identify the serious concerns we found during our visits regarding the quality and safety of the environment. The audits had failed to identify risks to people who used the service in order to keep them safe from harm.

The infection control audit was last completed in December 2013. Although the audit had identified failings throughout the home these had not been addressed. The provider's infection control policy stated, "The company quality audit will be completed and if necessary an action plan will be formulated and completed". This had not been done. An action plan had not been developed to provide information about how and when improvements would be made. The provider was unable to demonstrate that the audit had resulted in action being taken to improve the standards of hygiene in the home. There was not an effective system to assess the risk of and prevent, detect and control the spread of a healthcare associated infection.

We looked at the nutritional audit completed in April 2014. It had identified that there were 'gaps in recording' on people's fluid and nutrition charts, but actions on how this was going to be addressed and monitored were not in place. We had serious concerns about people's food and fluid intake and output charts and found discrepancies in accurate recording. This had not been identified in the home's audit.

The audits we looked at had failed to analyse and use the information gathered to identify non-compliance with the regulations and standards of care and welfare and safety to decide what would be done. This meant that the provider could not be assured through their systems that people were not harmed as a result of unsafe care, treatment or support.

The service gathered information about the safety and quality of the service by holding meetings for people who used the service. The deputy manager told us that the home had just held its first relatives meeting in April 2014. We looked at the minutes for this meeting. The minutes of the meeting cited thirteen concerns that relatives had raised. The minutes stated "There were many concerns regarding the life at Oaktree for people and there was a consensus that the relatives would like to meet with Four Seasons management as soon as it could be arranged".

We asked a member of staff, who had attended the meeting, if an action plan had been developed with regards to the concerns relatives had raised. They told us that an action plan had not been developed to address the concerns raised and that a meeting with management and the relatives had not been arranged. One relative we spoke with told us that they had attended the meeting and had not heard anything since. The area manager had signed to say that they had read the minutes, however no further action had been taken.

This section is primarily information for the provider

Action we have told the provider to take

Compliance actions

The table below shows the essential standards of quality and safety that **were not being met**. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activities	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	**Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010** **Respecting and involving people who use services**
	How the regulation was not being met: 17.-(1) (a) (b) People's privacy, dignity, and independence was not always respected. People's views and experiences were not taken into account in the way the service was provided and delivered in relation to their care.
Regulated activities	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	**Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010** **Care and welfare of people who use services**
	How the regulation was not being met: 9.-(1) (b) (i) (ii) People did not experience care, treatment and support that met their needs and protected their rights.
Regulated activities	Regulation

This section is primarily information for the provider

Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	**Regulation 14 HSCA 2008 (Regulated Activities) Regulations 2010** **Meeting nutritional needs**
	How the regulation was not being met: 14.-(1) (a) (c) People were not protected from the risks of inadequate nutrition and dehydration.
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	**Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010** **Safety and suitability of premises**
	How the regulation was not being met: 15.-(1) (c) (i) People who used the service, staff and visitors were not protected against the risks of unsafe or unsuitable premises.
Regulated activities	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	**Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010** **Staffing**
	How the regulation was not being met: 22. The provider had not taken suitable steps to ensure there were enough qualified, skilled and experienced staff to meet people's needs.
Regulated activities	Regulation

This section is primarily information for the provider

Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	**Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010** **Assessing and monitoring the quality of service provision**
	How the regulation was not being met: 10.-(1) (a) (b) The provider did not have effective system in place to identify, assess and manage risks to the health, safety and welfare of people using the service and others.

This report is requested under regulation 10(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The provider's report should be sent to us by 16 July 2014.

CQC should be informed when compliance actions are complete.

We will check to make sure that action has been taken to meet the standards and will report on our judgements.

About CQC inspections

We are the regulator of health and social care in England.

All providers of regulated health and social care services have a legal responsibility to make sure they are meeting essential standards of quality and safety. These are the standards everyone should be able to expect when they receive care.

The essential standards are described in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. We regulate against these standards, which we sometimes describe as "government standards".

We carry out unannounced inspections of all care homes, acute hospitals and domiciliary care services in England at least once a year to judge whether or not the essential standards are being met. We carry out inspections of other services less often. All of our inspections are unannounced unless there is a good reason to let the provider know we are coming.

There are 16 essential standards that relate most directly to the quality and safety of care and these are grouped into five key areas. When we inspect we could check all or part of any of the 16 standards at any time depending on the individual circumstances of the service. Because of this we often check different standards at different times.

When we inspect, we always visit and we do things like observe how people are cared for, and we talk to people who use the service, to their carers and to staff. We also review information we have gathered about the provider, check the service's records and check whether the right systems and processes are in place.

We focus on whether or not the provider is meeting the standards and we are guided by whether people are experiencing the outcomes they should be able to expect when the standards are being met. By outcomes we mean the impact care has on the health, safety and welfare of people who use the service, and the experience they have whilst receiving it.

Our inspectors judge if any action is required by the provider of the service to improve the standard of care being provided. Where providers are non-compliant with the regulations, we take enforcement action against them. If we require a service to take action, or if we take enforcement action, we re-inspect it before its next routine inspection was due. This could mean we re-inspect a service several times in one year. We also might decide to re-inspect a service if new concerns emerge about it before the next routine inspection.

In between inspections we continually monitor information we have about providers. The information comes from the public, the provider, other organisations, and from care workers.

You can tell us about your experience of this provider on our website.

How we define our judgements

The following pages show our findings and regulatory judgement for each essential standard or part of the standard that we inspected. Our judgements are based on the ongoing review and analysis of the information gathered by CQC about this provider and the evidence collected during this inspection.

We reach one of the following judgements for each essential standard inspected.

✓ **Met this standard**	This means that the standard was being met in that the provider was compliant with the regulation. If we find that standards were met, we take no regulatory action but we may make comments that may be useful to the provider and to the public about minor improvements that could be made.
✖ **Action needed**	This means that the standard was not being met in that the provider was non-compliant with the regulation. We may have set a compliance action requiring the provider to produce a report setting out how and by when changes will be made to make sure they comply with the standard. We monitor the implementation of action plans in these reports and, if necessary, take further action. We may have identified a breach of a regulation which is more serious, and we will make sure action is taken. We will report on this when it is complete.
✖ **Enforcement action taken**	If the breach of the regulation was more serious, or there have been several or continual breaches, we have a range of actions we take using the criminal and/or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers include issuing a warning notice; restricting or suspending the services a provider can offer, or the number of people it can care for; issuing fines and formal cautions; in extreme cases, cancelling a provider or managers registration or prosecuting a manager or provider. These enforcement powers are set out in law and mean that we can take swift, targeted action where services are failing people.

How we define our judgements (continued)

Where we find non-compliance with a regulation (or part of a regulation), we state which part of the regulation has been breached. Only where there is non compliance with one or more of Regulations 9-24 of the Regulated Activity Regulations, will our report include a judgement about the level of impact on people who use the service (and others, if appropriate to the regulation). This could be a minor, moderate or major impact.

Minor impact - people who use the service experienced poor care that had an impact on their health, safety or welfare or there was a risk of this happening. The impact was not significant and the matter could be managed or resolved quickly.

Moderate impact - people who use the service experienced poor care that had a significant effect on their health, safety or welfare or there was a risk of this happening. The matter may need to be resolved quickly.

Major impact - people who use the service experienced poor care that had a serious current or long term impact on their health, safety and welfare, or there was a risk of this happening. The matter needs to be resolved quickly

We decide the most appropriate action to take to ensure that the necessary changes are made. We always follow up to check whether action has been taken to meet the standards.

Glossary of terms we use in this report

Essential standard

The essential standards of quality and safety are described in our *Guidance about compliance: Essential standards of quality and safety*. They consist of a significant number of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. These regulations describe the essential standards of quality and safety that people who use health and adult social care services have a right to expect. A full list of the standards can be found within the *Guidance about compliance*. The 16 essential standards are:

Respecting and involving people who use services - Outcome 1 (Regulation 17)
Consent to care and treatment - Outcome 2 (Regulation 18)
Care and welfare of people who use services - Outcome 4 (Regulation 9)
Meeting Nutritional Needs - Outcome 5 (Regulation 14)
Cooperating with other providers - Outcome 6 (Regulation 24)
Safeguarding people who use services from abuse - Outcome 7 (Regulation 11)
Cleanliness and infection control - Outcome 8 (Regulation 12)
Management of medicines - Outcome 9 (Regulation 13)
Safety and suitability of premises - Outcome 10 (Regulation 15)
Safety, availability and suitability of equipment - Outcome 11 (Regulation 16)
Requirements relating to workers - Outcome 12 (Regulation 21)
Staffing - Outcome 13 (Regulation 22)
Supporting Staff - Outcome 14 (Regulation 23)
Assessing and monitoring the quality of service provision - Outcome 16 (Regulation 10)
Complaints - Outcome 17 (Regulation 19)
Records - Outcome 21 (Regulation 20)

Regulated activity

These are prescribed activities related to care and treatment that require registration with CQC. These are set out in legislation, and reflect the services provided.

Glossary of terms we use in this report (continued)

(Registered) Provider

There are several legal terms relating to the providers of services. These include registered person, service provider and registered manager. The term 'provider' means anyone with a legal responsibility for ensuring that the requirements of the law are carried out. On our website we often refer to providers as a 'service'.

Regulations

We regulate against the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009.

Responsive inspection

This is carried out at any time in relation to identified concerns.

Routine inspection

This is planned and could occur at any time. We sometimes describe this as a scheduled inspection.

Themed inspection

This is targeted to look at specific standards, sectors or types of care.

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