Laudcare Limited

Oaktree Care Home

Inspection report

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Ratings

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

Overall summary

This inspection took place on 8, 9 and 29 September 2015. We carried out this inspection because we had a number of concerns shared with us. These concerns came from a range of different sources including, relatives, health and social care professionals who had visited the service, South Gloucestershire County Council and a whistle blower. A whistle blower is a member of staff who works for the service and had reported concerns but not been listened to. These concerns were about the care and support people were receiving on the dementia suite. This was a focussed inspection looking at only the Dementia suite, in line with our procedures we have not changed the overall rating of this location.

We visited the service on 24, 26 and 27 February 2015. At that time, we rated the service as inadequate and identified a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. We visited the service again on 8 and 9 June 2015.

Summary of findings

We found some improvements had been made and rated the service as requires improvement. However, we identified two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Oaktree Care Home is registered to provide personal and nursing care for up to 78 people. The service is divided over two separate floors. The ground floor is for those who require nursing care and the upper floor is dedicated to those people living with dementia. At the time of our inspection there were 24 people living on the dementia suite.

There was a registered manager in post. 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.'

People were not always supported by sufficient staff. There was only one permanent qualified nurse employed to work on the dementia suite. The shortfall was being covered by agency and bank nurses who did not always know the people they were caring for. This resulted in communication not always being effective with health and social care professionals and had contributed to inconsistent recording in care documentation.

People were not always safe because where their care needs had changed or an incident had occurred, appropriate action had not always been taken. Incidents were not identified as potential abuse; they were not reported or investigated. This included reporting incidents and accidents to the local safeguarding team and submitting notifications to the Care Quality Commission (CQC).

People could not always be assured they were receiving their medicines as they wished. Staff were not always signing for creams and ointments so it was not clear if people were receiving these as required. There was a surplus supply of medicines that was being returned to the pharmacy. This could be an indicator that people were not receiving their medicines as prescribed by their GP. Medicines were not being stored safely in respect of controlled medicines.

Care records were not accurate or detailed enough and could potentially mean that people were not receiving the care and support they required. People did not always receive medical support and interventions in a timely way to ensure their health and well-being.

People were not always supported to make their own choices and where people had made advanced decisions these were not always taken into account. People's care was not personalised and did not reflect their individual needs and preferences.

There was a lack of meaningful activities for people on the dementia suite which was leading to some people feeling bored. Most people were disengaged and spent long periods of time with little or no stimulation.

Some staff were caring but this was not always consistent. Our observations throughout our visit, discussions with people using the service, their families and staff and examination of records, all gave the impression the service was task orientated.

The provider did not have effective systems in place to assess, monitor and improve the quality of care. Poor care was not being identified and rectified by the provider.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not always safe.

There was not always sufficient staff with the right skills working in the dementia suite.

Risks to people were not being assessed and monitored. Where risks had been identified there were no management plans in place. This was needed to provide staff with sufficient and up to date information which would ensure people were safe.

People were not always receiving medicines in accordance with their wishes. It was not always clear that people were receiving their medicines as prescribed.

Staff were aware of what constituted abuse but this was not always acted upon because some allegations of abuse had not been shared with the local safeguarding team. Failure to report meant that the service could not be monitored to ensure swift action had been taken to reduce any further risks to people.

Is the service effective?

Inadequate

The service was not effective.

People's care records were not always maintained accurately and completely to ensure there were receiving care that was safe and effective.

There were delays in people receiving support from other health professionals as staff had not acted on their advice.

People's wishes were not always being followed.

Staff did not always have the skills, understanding to support people living with dementia.

Is the service caring?

Inadequate

The service was not always caring.

We observed some staff treating people with kindness. Some staff failed to notice when people were anxious and respond to their non-verbal communication.

There was minimal social interaction with people. Staff appeared to be task orientated and did not spend time talking to people. There was a lack of choice and control given to people in their day to day lives. Activities were not readily available to support people with their emotional and social needs.

Staff were not always knowledgeable about people's life histories enabling them to provide care that was centred around the person.

Is the service responsive?

Inadequate

The service was not responsive.

Summary of findings

This was because people's individual needs were not always planned for, evaluated or delivered consistently. In some cases, this meant that people were also not having their individual preferences met.

Is the service well-led?

Inadequate

The service on the dementia suite was not well-led.

There was a lack of leadership on the dementia suite. Staff did not know people well enough to meet their care and support needs. This meant people could not be assured they were receiving safe, appropriate care which was meeting their personally preferences.

Systems were not being operated effectively to assess and monitor the quality and safety of the service provided.

Notifications required by law had not been sent to the Care Quality Commission as required.

Oaktree Care Home

Detailed findings

Background to this inspection

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

This inspection took place on the 8, 9 and 29 September 2015 and was unannounced. The inspection team consisted of two inspectors and a specialist professional advisor on 8 and 9 September 2015. A Care Quality Commission pharmacy inspector completed an inspection on 29 September 2015. We completed this inspection as we had received a number of concerns from relatives and health and social care professionals about the care and treatment that people were receiving on the dementia suite. We spent both days inspecting the dementia suite.

Prior to the inspection we looked at information about the service including notifications and any other information received by other agencies. Notifications are information about specific important events the service is legally required to report to us.

We conducted two Short Observational Framework for Inspection (SOFI 2) assessments. One on the 8 September and one on the 9 September 2015. SOFI 2 provides a framework for directly observing and reporting on the quality of care experienced by people who cannot describe this for themselves.

We looked at 11 people's care records to see if they were accurate and up to date. We also looked at records relating to the management of the service. These included medicines administration records, staff rotas, training records and audits that had been completed on the dementia suite.

We spoke with a registered nurse, an agency qualified nurse, eight care staff, ten people who used the service, four relatives, the registered manager, the regional manager, the provider's dementia specialist, a peripatetic manager and the provider's care quality facilitator.

Inadequate

Is the service safe?

Our findings

People were not always cared for by sufficient numbers of appropriately skilled and experienced staff. The provider used a dependency tool to calculate the staff required to meet people's needs. The registered manager told us they were providing staff over and above that identified by this tool. For example, the dependency tool stated there should be 4.2 care staff in the morning however; the provider was staffing the dementia suite with six care staff and a qualified nurse.

The registered manager told us there should be a qualified nurse on duty at all times in the dementia suite, in accordance with the staffing dependency tool. When we inspected there was only one permanent qualified nurse employed to provide nursing care to the people living on the dementia suite. The shortfall of hours was being covered by bank or agency nurses.

On the days we inspected the same qualified nurse was present throughout, working long days on each day. This nurse was due to take some time off on the first day of our inspection as they were covering the absence of another qualified nurse. This would have meant a qualified nurse from the nursing suite downstairs would have been covering for several hours. Therefore, there would have been insufficient skilled and experienced staff working on the dementia unit. The qualified nurse changed their plans as a result of our arrival and remained present throughout the day. We saw from the duty rota that on the 24 August 2015, there had not been a qualified nurse working on the dementia suite for a period of twelve hours. Again this meant there were insufficient numbers of appropriately skilled and experienced staff. The registered manager confirmed there was no qualified nurse on duty on the dementia suite and the qualified nurse from downstairs had administered the medicines.

We found that the registered person had not ensured there were sufficient staffing at all times. This was in breach of regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Staffing.

The registered manager told us they were using regular agency staff to cover the shortfalls. However, health and social care professionals provided feedback that often these staff did not know people well enough to provide information to them.

During our inspection we identified several occasions where there were not enough staff to provide care and support to ensure people's safety. We saw people identified at being of risk of choking, being left unsupported with pureed food and drink for two to three minutes at a time. There was a risk that people were not safe during this period of time. There were times throughout the day when staff were engaged in providing personal care in people's rooms, with no staff present in the lounge areas to care for people.

On 9 September, we were concerned about a person's health, as was another person using the service; this was because they told us they were breathless. We pressed the call bell in the person's room. Care staff did not attend for two minutes. We looked for staff and could not find anyone. We then pressed the emergency call bell to alert staff and waited for a further two minutes. We were told by the qualified nurse that three staff were supporting another person and they could not hear the call bell from the person's bedroom. The remaining two staff working on the dementia suite were either on their break or downstairs photocopying. It was the member of staff that was on break and the one downstairs that responded. This meant people were at risk as staff were not able to attend promptly to ensure people's safety and their care needs were met.

Relatives we spoke with told us they were concerned there was not enough staff and that agency staff were used a lot. A relative expressed their concerns about staffing levels, particularly at the weekend. They told us, "Sometimes there was no one in the lounge at all as all the staff were

involved with other residents". They told us sometimes there could be ten people in one of the lounge areas and no staff present to support them.

We found that the registered person had not ensured there were suitably qualified, competent, skilled and experienced staffing at all times. This was in breach of regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Staffing.

Risk assessments were in place. However, these were not consistently followed. For example, a person who had been assessed as being at risk of developing pressure wounds had an assessment in place that clearly stated they needed to be re-positioned every two hours. There were no positional charts to record these positional changes. The care worker with responsibility for the person's care said

they were not aware the person needed to be assisted to change position every two hours. They said the person was only repositioned when their continence needs were met, which they said, "Is nowhere near every 2 hours". Another person's positional change was being recorded. However, the staff were consistently recording the person as being in the same position and where a change of position was recorded, information was not sufficiently detailed, for instance staff had recorded 'back tilt' but given no indication as to whether it was left or right. This meant that people could not be assured they were receiving care that was planned, safe, appropriate and minimised the risks of skin breakdown from being in the same position.

We found that the registered person had not ensured people were receiving care and treatment that prevented avoidable harm or risk of harm. This was in breach of regulation 12(1) (2) (a) and (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Safe Care and Treatment.

Accidents and incidents were not always recorded. We saw that a person had bruising and when we asked staff they told us the person had fallen the week before. When we checked the care records for this person there was no information about this incident. This meant people were at risk as accidents were not being recorded or investigated to ensure any required action was taken to keep people safe.

We found that the registered person had not ensured people were receiving care and treatment that prevented avoidable harm or risk of harm. This was in breach of regulation 12(1) (2) (a) and (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Safe Care and Treatment.

We saw an incident recorded on a behavioural monitoring record dated 22 August 2015 where a person had aggressively thrown a cup of tea at another person. When we looked at both people's care records and daily diaries there was no record of the incident for either person. There was no record that either person had been checked for any burns or injuries. The lack of recording meant that staff were unable to follow this up on subsequent days to check for any harm or changes to the people involved. There was no reference to this incident recorded on the staff handover record so that they could continue to monitor the individuals involved. There was no care plan, giving guidance to staff on monitoring the behaviour of the person who had thrown the hot drink.

We found that the registered person had not ensured people were receiving care and treatment that prevented avoidable harm or risk of harm. This was in breach of regulation 12(1) (2) (a) and (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safe Care and Treatment.

We asked the nurse in charge if this had been reported to the local safeguarding team, they were unsure so we spoke with the registered manager. This was reported by the registered manager to the local safeguarding team on the 9 September 2015 in response to our findings. The service had failed to report safeguarding concerns to the local safeguarding team and the Care Quality Commission. This meant that external agencies could not respond swiftly to ensure the provider had taken appropriate action in safeguarding people.

We found that the registered person did not have suitable systems to protect people in the event of an allegation of abuse ensuring this was reported promptly with appropriate action taken to protect people. This was in breach of regulation 13 (1), (2), (3) and (4), (d) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Safeguarding service users from abuse and improper treatment.

Staff were able to describe the action they would take if they thought people were at risk of abuse, or being abused. They were also able to give us examples of the sort of things that may give rise to a concern of abuse. There was a safeguarding procedure for staff to follow with contact information for the local authority safeguarding team. Staff we spoke with told us they had completed training in keeping people safe. Staff knew about 'whistle blowing' to alert management to poor practice. However, these systems were not always being followed in respect of safeguarding people.

Since the last inspection in June 2015, we have received 16 safeguarding alerts. These had been raised by the registered manager, healthcare professionals and relatives. The local authority was still in the process of completing their investigations for some of these alerts. There was on-going safeguarding monitoring in place by the local authority because of the high number of concerns since the beginning of the year. The local authority has placed a stop on any new admissions to the dementia suite until improvements could be sustained. The provider has agreed

Inadequate

Is the service safe?

to this arrangement and has confirmed that they will not admit any new people to the dementia suite, until they were satisfied people were receiving safe and appropriate care.

During our inspection on 29 September 2015 our pharmacist inspector found that a new unit manager had been appointed to the dementia suite. We found that improvements were needed to the handling of medicines to make sure people's health was protected.

Some people were prescribed medicines to be given 'when required' for example to treat anxiety or pain. Some people had protocols in place with giving staff additional information to help them give these medicines appropriately. However, these were not always in place or had not been updated to reflect changes in medicines. In some cases these simply repeated the information on the medicines label and did not give any additional, more specific guidance; such as whether the person was able to say if they were in pain or what the signs of needing pain relief might be. This increased the risk that these medicines may not be given in a safe and consistent way particularly if staff did not know the people concerned.

Staff told us that two people may need to be given their medicines covertly. This meant if the person refused to take their medicines staff could disguise them in food or drink to make sure they were taken. One person had appropriate agreements documented to safeguard them but staff had not confirmed with the pharmacist that it was safe to give their medicines using the proposed method. Another person had their medicines reviewed by the doctor to reduce the number taken and their agreement to administer covertly if needed. There was no care plan to support this. There was a lack of information on how people's medicines should be given and these were not available with the person's medicines administration records. This increased the risk that medicines would not be given in a safe and consistent way.

Cream and ointments prescribed for people were kept in their bedrooms and applied by care staff. Staff recorded the application of creams and ointments on forms kept in people's rooms. Records were not always completed so it was not clear whether people had not needed the cream or ointment or whether staff had applied it but not recorded it.

Medicines were stored securely. A medicines refrigerator was available on the dementia suite. We saw records of the refrigerator temperature but there were gaps in these records. The record sheet stated that checks should be completed every day and the acceptable temperature range was 2 to 8 º C. Temperatures were recorded on 48 of 138 days between 19 March and 3 August 2015. The maximum temperature of the refrigerator was recorded as being between 19 and 25 º C on 39 of these days. There was no record of any action taken to make sure the refrigerator was working correctly. So staff were not able to assure themselves that medicines requiring refrigeration were safe to use.

Staff told us they ordered a replacement cupboard for storing controlled drugs, which need additional security, and were waiting for this to be attached to the wall. The interim arrangements did not meet the legal requirements of the Misuse of Drugs, Safe Custody Regulations 1973. Suitable records were kept of the use of these medicines and showed they had been looked after safely.

We found the registered manager had not ensured there safe systems in respect of the administration and storage of medicines. This was in breach of regulation 12 (1) (2) (f) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Safe Care and Treatment.

This was a focussed inspection and not all areas under safe were looked at during this inspection. For example, we did not look at the recruitment of staff. During the inspection in June 2015 we found there was a breach of regulation relating to the recruitment of staff. This was because not all information had been received before staff started working in the home and there was no risk assessment where a member of staff had a criminal record. The provider submitted an action plan within the timescale. We will follow up this breach at the next inspection of the service.

Inadequate

Is the service effective?

Our findings

Concerns had been raised with us about the care and welfare of the people living in the dementia suite. The concerns had been raised by relatives, health and social care professionals and the safeguarding team. This was because people were not always receiving care that was planned and meeting their health care needs. Risks to people had increased as staff did not always know people sufficiently well or have access to clear records to enable them to provide consistent, effective treatment. This included meeting people's health care needs, monitoring wound care and supporting people in a person centred way. This was a focussed inspection and not all areas under effective were looked at during this inspection.

People's health care needs were not always met effectively. We received feedback from the GP practices people used, raising concerns that their advice was not always followed and requests they made not always actioned. For example, one GP had requested a blood test on the 24 July 2015 and this was not done until the 7 August 2015. The GPs told us basic observations were not being completed in respect of pulse, blood pressure and temperature when people were unwell which could lead to a delay in diagnosis. One person had not had these monthly observations completed for a period of three months. This meant people were at risk of their health care needs not being met effectively.

We saw in the dementia suite's diary a message stating that a person's bloods needed to be taken on the day of the inspection. When we checked the professional record there was no information relating to the blood test detailing who made the request or the reason. The qualified nurse told us they would have to contact the surgery prior to carrying out the procedure for clarification. The lack of recording meant people were at risk of not receiving safe and appropriate treatment.

We found that the registered person had not ensured people were receiving care and treatment and working collaboratively with other professionals. This was in breach of regulation 12 (1), (2), (a), (b) and (i) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Safe Care and Treatment.

People were not always able to make their own choices and decisions about their care. The provider had policies and procedures on the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). Information in people's support plans showed the service had not always assessed people in relation to their mental capacity. A number of people had no assessment of their capacity to make decisions in their care plans. A health and social care professional visiting the service to provide advice and guidance on this area, told us they had identified a number of people for whom this was required and had not been put in place.

We saw that one person who had been admitted to hospital, had made a decision in advance that they did not want to be hospitalised. This decision was clearly documented in their care plan. There was no reason recorded in the person's care plan why their wishes had not been acted upon. This meant that choices and decisions made by people were not always respected.

We found that the registered person had not ensured people wishes and preferences had been followed in respect of their care and treatment. This was in breach of regulation 9 (1) (a) (b) and (c), (3) (a) (b) and (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Safe Care and Treatment.

We looked at whether the service was applying DoLS appropriately. These safeguards protect the rights of people by ensuring if there are any restrictions to their freedom and liberty these have been authorised by the local authority as being required to protect the person from harm. The registered manager told us they had submitted applications in respect of everyone living on the dementia suite. Copies of the applications were kept in the registered manager's office and kept under review. Care staff on the dementia suite were not always sure if a person had a DoLS authorisation in place and they had to seek clarification from the manager. This meant people could not be assured they were being supported consistently in respect of the authorisation. A health and social care professional visiting people, to assess if they were being deprived of their liberty, told us they had previously had concerns but felt more confident the service was working positively to comply with these requirements.

A number of people required assistance with moving and handling. This sometimes involved staff using mobile hoists and other lifting equipment. Staff had received training in moving and handling. However, we saw two examples of an underarm lift being used. This could result in bruising and

Is the service effective?

is uncomfortable for the person. We also saw on one occasion a person being hoisted using a mobile hoist. The person looked startled and confused and staff were not talking with the person to explain what was happening.

One person had been assessed at being at risk of malnutrition and skin breakdown. Their assessment stated their weight should be recorded regularly. In the person's care plan, the last record of their weight was dated June 2015. The weight recorded showed a 5-10% decrease in the person's weight from the previous month. We did find a weight recorded for July 2015 in the person's daily records however this had not been transferred to the care records. The weight recorded for July 2015 showed a further decrease in the person's weight. We clarified the recording of this with the nurse in charge and were told the recorded weight needed to be transferred to the care records, because people's weight was monitored from those and not the daily records. This meant people were not always receiving safe care in accordance with their individual assessed needs.

The provider used a recognised assessment tool to assess if people were at risk of choking. The tool produced a numerical score. One person had been scored as having a risk of choking at 30 in October 2014. This had been calculated incorrectly and should have been 36 putting them at a higher risk of choking. The organisational policy stated that if someone had a score of 25-49 staff should consider a referral to the speech and language team for a swallowing assessment. There was no evidence that this has been completed. This meant the staff had not sought professional advice on how best to support this person effectively. We checked the guidance available to staff in the person's bedroom, there was no mention of the risk of choking, the information recorded stated 'I have no swallowing difficulties'. This meant this staff could not respond to this person ensuring their care needs were met safely and appropriately.

We saw one person was having regular blood tests to check their blood sugar level. However there was no care plan in place to support this. There was no information for staff about what these results should be or what action to take if results were outside the correct range. This meant this person was at risk of not receiving safe and appropriate care.

Several people were prescribed thickeners to add to their drinks to help swallowing. Care staff told us there was information in the office describing who needed thickener to be added to their drinks and how much, but this was not currently available due to the office being redecorated. One person had a large supply of thickening agents. Their care records included an assessment in April 2015 that they were at risk of choking. According to the provider's information this should have triggered a referral to the speech and language team (SALT). There was no evidence that this had taken place, to ensure this person received appropriate and safe treatment for their condition. Staff were not following recent NHS recommendations for the appropriate use of thickening agents. The new unit manager told us they had now made an urgent referral.

Several people were prescribed medicines to be given when required for agitation. Records showed that most people had not needed these medicines in the current month. We looked at the care records for one person but found there was no care plan in place to help staff support the person, if they became agitated. There was no indication of when it would be appropriate to give the medicine. In some cases staff had recorded the reason for giving medicines for agitation on the back of the person's administration record but this was not done consistently. Staff were not recording in people's daily diaries moments when people were unsettled, anxious or agitated. This meant that staff could not monitor effectively any changes to people's well-being. This increased the risk people would not receive safe and appropriate treatment.

We found that the registered person had not ensured people were receiving care and treatment that prevented avoidable harm or risk of harm. These were breaches of regulation 12(1) (2) (a) and (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Safe Care and Treatment.

The provider had put in place a number of improvements to the environment since our last inspection in June 2015. For example, a small lounge area had become an activity room and a music lounge had been created. The registered manager told us some new furniture for the communal areas had been ordered along with new bed linen and crockery.

People seemed to enjoy the new communal areas and staff spoke positively about these changes. However, a relative

Is the service effective?

raised concerns that some people had to use lounges further away from the 'hustle and the bustle' of the nursing office and the entrance to the dementia suite often with no staff presence for long periods of time.

The environment was not dementia friendly. For example, bedroom door number name plates were often too high for people to see, doors to ensuite facilities looked like wardrobe doors and many people's rooms had few personal objects. Signage throughout the dementia suite was not clear and the layout often confusing. This meant people found it difficult to find their way around and were likely to mistake other people's rooms for their own.

There were no memory boxes outside bedroom doors to prompt people on the location of their bedroom. Memory boxes are used to enable people to personalise the entrance of their bedroom with objects and photographs. These have proved beneficial for people with dementia. There was no distinction of colour to enable people to move around the home and recognise the corridor where their bedroom was situated. Corridors came to an abrupt end with no comfortable seating or a defined area such as rummage boxes which would aid communication or occupy a person.

One person's care plan stated their room should be uncluttered to prevent falls and they should have access to their ensuite to assist with continence. However, we observed that their bedroom had a wheelchair and various cushions blocking the ensuite. When we checked the person's care plan there was no mention of this person using a wheelchair, in fact their care plan stated they could mobilise independently. A member of staff confirmed this. This meant this person's bedroom was cluttered and being used to store equipment not belonging to them.

We found that the registered person had not ensured the dementia suite was suitable for people living with dementia. This was in breach of regulation 15 (1) and (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Premises and equipment.

Staff confirmed they had received training suitable to their role. This included an induction for new staff. Agency staff received an induction to their role. However; it was clear from the concerns that this was not always effective.

Comments from professionals was that often the agency staff did not know people and record keeping and communication was generally poor which meant that people were not receiving safe, consistent and appropriate care.

We were forwarded the training matrix after the inspection which showed that staff were provided with moving and handling, safeguarding adults, first aid, food hygiene and fire training. This was updated at frequent intervals. Staff told us training was delivered electronically and through workbooks.

We observed staff not responding appropriately to people living with dementia. For example, a member of staff stated, "Eat your dinner". This person appeared to have forgotten how to use their knife and fork, no assistance was offered and this person continued to eat with their fingers until we stepped in and gently placed the fork to the front of the plate. Another member of staff said, "be calm" with no thought to finding out why this person was asking for help. There was very little use of people's names when staff were addressing individuals. Using the person's name would help them understand staff were engaging with them. This also showed a lack of respect for the person. The actions of the staff showed no understanding of dementia and how it affects people.

We discussed the training the staff received in relation to supporting people living with dementia. The regional manager and the registered manager stated they were aware that the present training was not fit for purpose and this needed to be reviewed. The organisation had arranged for their dementia specialist to spend time in the service to provide additional training and support to the team. The dementia specialist was present during our inspection and told us they planned to spend two to three days a week with staff over the next couple of weeks. This was to offer guidance, support and training. In addition a peripatetic manager was providing support and guidance to the team. They told us they had started five days before our inspection to act as a positive role model for staff in supporting people with dementia. The peripatetic manager was employed by the organisation to provide management support where it was needed.

Inadequate

Is the service caring?

Our findings

Concerns had been raised with us about the care and welfare of the people living on the dementia suite. The concerns had been raised by relatives, health and social care professionals and the safeguarding team. This was because staff did not always know people well enough to ensure they received care that was person centred and were treated with dignity and respect. This included people being ignored when it was evident they needed assistance, treated in an undignified manner and people being told to shut up when they were visibly upset. We observed some people being supported in a caring manner but this was not consistent.

People told us staff were caring. One person said, "The staff are all very nice", another person said, "The staff are very kind", a third person told us, "It's alright here, I have been here a long while, most of the carers are alright but they are very busy". Relatives gave mixed feedback regarding the caring approach of staff. One relative said, "Some care staff are good, others are not". Another said, "The staff are usually caring but I am concerned over (Person's name) moving to another home".

Prior to the inspection we had received some information of concern about how people were being treated. An example was where a care worker had taken a person from the bathroom partially naked because it was easier to dry the person in their bedroom. Another example was where care workers were talking in the lounge area about showering a person stating, "that she smelt" in front of other people living in the home. This behaviour from staff showed no respect for people and was degrading.

Some care workers were not caring in their approach to people. We observed a care worker supporting a person with their lunchtime meal, they did not engage with the person at all apart from the function they were performing. Another care worker moved a person in a wheel chair without telling them they were going to do this or asking their permission. This member of staff responded to the same person who was calling for help telling them "to be calm". There was no other interaction to ascertain what the person needed or offer any reassurance. A third care worker removed a clothes protector from a person, without asking their permission or informing the person this was what they were going to do.

Two people were sat in the music room listening to a CD that had got stuck. One member of staff walked into this area without even noticing the music was stuck and they did not acknowledge the two people. It was only when we pointed out to the registered manager that the music was stuck that this was addressed. This showed a total disregard for the people sitting in this area. The only time people were spoken with during this ten minute period was to ask if they wanted a drink. They were not asked what they wanted and were given a cup of tea. During lunch we did not see people being offered a choice in relation to their main meal or pudding. We were told that there was only one choice for pudding unless people were diabetic and then yoghurt was available. This showed not only a lack of respect for people but did not promote involvement of people in making decisions in their day to day life.

Throughout our visit we observed staff providing care and support to people. Staff were often focused on the task rather than the person. We saw few examples of staff sitting talking with people. Staff often appeared hurried and rushed, moving quickly from one task to another.

When we spoke with staff about people's interests, hobbies and life stories in respect of employment. Staff were not knowledgeable about these areas. We were told that one person enjoyed a 'pint' and spending time with family, but they could not recall when the person had been taken by staff to the local pub. The nearest pub was less than a 5 minute walk away from the home. They had no other insight into this person in respect of employment or other interests they had prior to moving to Oaktree Care Home. This did not help in enabling them to foster positive relationships with the person. This lack of information contributed to staff being task orientated as they had little understanding of the person, their personalities, interests or attributes.

We completed observations at lunchtimes and in communal areas both before and after lunch. We found there was no real sense of fun or enjoyment and when opportunities for this did arise, staff did not make the most of these. For example, during a celebration afternoon tea, one person started to sing. Staff could easily have joined in and promoted a sense of joy and celebration. As they did not, the song fizzled out and a solemn atmosphere returned.

During breakfast staff were busy making drinks. Two people were becoming vocal, another was shouting help and the

Is the service caring?

fourth started shouting. Staff responded to the fourth asking them why they were shouting. The person responded, "Cause everyone else is". The staff completely ignored all four people and carried on making the drinks. This showed a total lack of regard for the people that were present in the dining area.

In another example of a task based rather than caring approach, we heard a person crying out 'help me, help me'. A care worker walked by pushing a hoist and did not acknowledge the person. The person was standing and seemed unsteady on her feet. We called to the care worker who said, 'I'm just going to….' and carried on walking around the corner of the corridor. A senior manager saw this and went to the person's assistance. On another occasion during lunch we saw a staff member 'telling' a person rather abruptly to, "Sit down and have your pudding".

We found that the registered person had not ensured people were treated with dignity and respect. These were breaches of regulation 10 (1) and (2) (a) and (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Dignity and Respect.

We did see some examples of staff showing a caring approach. For example, a care worker assisted a person into the lounge. They acknowledged the person was interested in a television programme and ensured the person was able to see the television. On another occasion, we saw a care worker complementing a person who had just returned from the hairdressing salon on their hair. The person clearly enjoyed the interaction which visibly contributed to their sense of wellbeing. During lunch we saw a staff member asking someone if they wanted a clothes protector and speaking very politely with the person. After lunch this staff member told us, "(Person's name) is eating much better now. We arranged a SALT assessment and they are now no longer having a mashed diet and (Person's name) is enjoying food and eating more". A SALT assessment is an assessment carried out by a speech and language therapist.

Visitors told us they could visit the home whenever they wanted and they could meet with their relative in private if they wanted. We observed some visitors taken part in an activity that was going on and being offered refreshments.

Care plans did not consistently show that people, or where appropriate their family, had been consulted on the care and support they received. We saw two examples of 'do not attempt cardiac resuscitation (DNACR) forms where decisions were recorded that people were not to receive treatment in the event of cardiac arrest. However, they did not include a record of discussion with the person or family representative.

We found that the registered person had not ensured people or their representatives were involved and consulted in the care and treatment. This is a breach of regulation 9 (1) (a) (b) (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Person Centred Care.

We asked staff we spoke with whether they would be happy for a relative of theirs to be cared for on the dementia suite. Care staff and senior managers consistently replied that they would not be happy for a relative of theirs to be cared for there at this moment in time.

Inadequate

Is the service responsive?

Our findings

People's care records were difficult to use and were not person centred. We noted that this had been the case at our previous inspection on 8 and 9 June 2015 and little progress had been made in rectifying the breach. The provider submitted an action plan that stating they would be compliant by 30 September 2015. The peripatetic manager told us they were introducing new files that had an index and all the old information was being transferred across to the new files. The care records were not regarded as helpful by care staff, nursing staff, or visiting health and social care professionals. A community nurse visiting the home said, "I do not like the layout of these, it does not make it easy to read or find information".

Information was difficult to navigate as staff had recorded information in the incorrect sections of the care plan documentation. For example weight monitoring had been recorded in the person's daily diary rather than the nutritional care plan. Another example was in the sleep care plan, staff had written the person was at risk of social isolation. There was no link to sleep and there was no other mention in the plan of care how staff would reduce this risk. Other examples seen included where staff had recorded incidents on behaviour charts but not transferred this to the care plan or the daily diaries. For example a person had spilt a hot cup of tea causing a red mark, there was no care plan or risk assessment in place to guide staff on minimising any further risks. Another example was where an incident had been recorded in relation to a person's behaviour in the sleep care plan about wandering into someone else's room. There was no care plan or risk assessment detailing how the staff were responding to the person's care and support needs. The inconsistent recording of information meant that care was difficult to evaluate and adapt to the changing needs of people.

When plans had been reviewed this was recorded in the evaluation of the care plan but where care needs had changed, a new care plan had not been written. There were numerous examples found during this inspection where people's needs had changed and the care plan had not been updated. For example, one person had a pressure wound; this was recorded in the skin integrity evaluation record. There was no new care plan guiding staff on the treatment of the pressure wound which would enable them to monitor the healing process. The qualified nurse told us they would have expected a new care plan to have been written as this was the company's policy. The daily diary for this person stated skin intact but this was not the case as this person had a skin tear and a pressure wound on their foot. This meant ongoing monitoring for this person would have been difficult due to the inconsistent record keeping and any changes to the person's condition may not have been responded to.

We found that the registered person had not maintained accurate records, complete and contemporaneous record of each person. This was a breach of 9 (2) (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Good Governance.

There was no overview of each person in the care file which would have been useful for new staff including bank and agency. Staff would have to read the whole care file to fully understand the care and support needs of the person. This would have included the evaluation records where changes to the plan had been noted.

We saw examples of the service not responding to people's needs as a result of poor recording of information. For example, one person's care records included an entry when they were admitted to the service with a history of 'frequent UTI's' (Urinary Tract Infections). However, this had not been followed through to the person's care plan so this could be monitored in respect of infections. The same person's care plan stated they were to be monitored every hour at night. Records of these hourly checks showed many gaps covering several hours. This meant the person was either not being monitored as required in their care plan or, monitoring was taking place but not recorded.

Several people, who had been assessed as needing regular changes of position, did not have records of this happening. This meant people were either not being repositioned as required in their care plan or, they were but this was not being recorded.

We saw the nurse giving some people their morning medicines on the dementia care unit. The nurse was from an agency and had not worked on the unit before. We saw some people were given their morning medicines at 12:00. The nurse told us this was partly because people had been asleep. This meant there was a risk that people may not receive medicines such as pain relief at an appropriate time of day.

Inadequate

Is the service responsive?

There was no information with people's medicines administration records explaining how people liked to take their medicines. The agency nurse said if she had any difficulty she would have asked the care staff for advice. However lack of written information increased the risk that people would not receive their medicines in the way that best suited them.

A person who had moved from the nursing suite to the dementia suite in March 2015 had not had their care plan updated and their care plan was incomplete. There were a number of blank templates in respect to meeting this person's needs. This person had been found naked in another person's room ensuite in March 2015. No further guidance on how to meet this person's needs had been recorded in their care plan. We saw an entry in the communication book that this person was to be cared for by female staff only. However, this information had not been transferred to the person's care plan. This meant this person was at risk of their needs not being met appropriately.

Another person had choked on food in August 2015. The person's risk assessment had not been updated following this and the service had not ensured specialist advice for reducing the risk of choking had been obtained. This meant the person was at risk of choking again in the future and the staff had not responded to their changing needs.

Care records did not contain person centred information to help staff form relationships and engage in meaningful conversation with people. There were no life histories and minimal information sought from families and friends about the person. We spoke with one person who had lived at the service for five years. This person said they enjoyed going to the pub and talked with us for some time about their previous employment. When we spoke with staff they had little knowledge of this person's life history or their likes and dislikes. This meant people were at risk of receiving care and support that did not take into account their likes and dislikes and preferences.

We observed a person trying to attract staff's attention by banging a cup on the table, staff completely ignored this. Another example involved a person touching the table beside them and then making a cup motion with their hands to their face. Staff did not attempt to find out if this person wanted a drink. A further person was becoming upset and calling out to staff. We sat with the person and it was clear this person had been incontinent. Staff had failed to pick up on people's non-verbal communication and take responsive action to their requests for assistance. There was very little information about how people communicated in their care plans to aid staff.

We found that the registered person had not ensured people or their representatives were involved and consulted in the care and treatment to ensure it was person centred. This is a breach of regulation 9 (1) (a) (b) (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Person Centred Care.

People said they would like more activities both at the service and trips out. One person said, "It's boring, I don't want to just sit around all day". One relative told us they had become so frustrated with the lack of activities, they had researched possible entertainers and trips and given this information to the registered manager. They said the manager had acknowledged there were no activities for people but had not made any changes as a result. One relative told us they felt people were being deprived of contact with the outside world and feared that their mother was being left to die. They said, "It's frustrating".

The activities organiser told us there were no records kept of activities people had participated in. They told us there was a weekly plan of activities but the activity co-ordinator said it was often changed. Staff told us people rarely (if ever) had the opportunity to leave the suite unless families supported them with this. There was very little information in care records detailing what activities people would like to participate in and how staff could support them with meaningful activities.

We found that the registered person had not ensured that care and treatment was meeting people's needs and reflected their preferences in ensuring activities were taken place. These were breaches of regulation 9 (1) (a) (b) and (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Person Centred Care.

We saw some examples of individual members of staff encouraging people to undertake activities but also saw many missed opportunities for this. For example, when staff were preparing the lounge area for a celebratory party much time was taken in folding serviettes and laying the table. No attempt was made to involve people in this.

Inadequate

Is the service well-led?

Our findings

The culture of the service was not person centred. Our observations, discussions with people using the service, their families and staff and examination of records, all gave the impression of the service being task orientated.

The staffing structure on the dementia suite consisted of a unit manager, nursing staff (although only one was permanently employed to work on the suite), two senior care workers, activities staff and care staff. We spoke with the two senior care workers and found they, along with some of the care staff, were enthusiastic regarding their roles. However, they were not receiving the support and direction they both needed and wanted. A number of senior staff were present during our inspection but we saw few meaningful examples of coaching or role modelling of good care and support practice. We were told three days after the inspection that the unit manager on the dementia suite had left the employment of Oaktree Care Home.

We asked how information was shared between staff. An agency staff member told us they were made aware of people's needs through a verbal handover at the start of each shift. They told us staff then will continually offer guidance when asked. There was a handover record but this just detailed each person's name, there were no other instructions for staff to enable them to support people consistently or act as an aide memoire. Staff were reliant on verbal handovers. Health and social care professionals and relatives had all raised concerns in respect of the lack of continuity of care and the sharing of information between staff, which had meant the service had not been responsive to people's ongoing and changing needs. Staff have stated to health and social care professionals, "I was not working on that day" or, "I am only temporary I do not know". A relative told us, "You rarely see the management of the service at weekends and the majority of the time it is agency staff on the dementia unit".

During our inspection we requested information to help us in our role. We often had to ask several times for information and it was clear the information we requested was not always easy to find. This was a concern, as the information we required was the sort of information that would be used to determine if the service was meeting people's needs and providing good care. As a result it should be easily accessible to managers of the service. We also saw several examples of incidents that had not been communicated to the manager of the service. This included information regarding accidents and incidents which could affect people's safety.

The registered manager told us they completed a daily walk around which included looking at the environment, people's care records and included speaking with staff, people who use the service and their relatives. They told us they used an electronic device to record the information, which was then shared with the provider. We asked how they could review the information and share this with us. The registered manager was unable to do this. The regional manager was able to share with us the findings of the last month. This did not highlight the level of concerns we found during our inspection indicating most areas such as care planning, delivery of care was good.

Care plan audits had been completed on some of the care plans we saw. We looked at 11 people's care records and found shortfalls and inconsistencies in each person's care plan. The audits did not reflect this and as a result the audits were ineffective. The audit had focused on weight monitoring, nutrition and skin integrity and choking. One audit identified that one person did not have any pressure wounds on the 4 September 2015. However, this person had a pressure wound on their heel.

When we visited on the 29 September the newly appointed unit manager and the peripatetic manager were in the process of sorting through large quantities of creams, ointments and other medicines that had been prescribed for people but unused. We saw one container of urine testing sticks with a use by date of May 2014. This demonstrated that suitable systems were not in place for checking of the ordering of the medicines and mitigating risks to people.

The registered manager told us that the qualified nurses were responsible for ensuring care plans were up to date and relevant to meet the individual's care and treatment needs effectively. There was only one registered nurse employed on the dementia suite and they were responsible for reviewing and updating all 25 people's care plans. In response the registered manager told us the senior staff would be receiving training in this area.

Agency nurses were employed to cover the shortfalls on the dementia suite. During August 2015 the duty rota indicated agency nurses were handing over to other agency staff on a

Is the service well-led?

regular basis. Over a three day period there were no permanent qualified nurses working on the dementia suite. During this period there was evidence of poor communication with professionals, care plans not being written in respect of changes to people's care needs and incidents and accidents not being reported. This showed there was a lack of leadership on the dementia suite and this was putting people at risk of unsafe and inappropriate care.

We found that the systems had failed to ensure ongoing compliance and to continually assess, monitor the quality of the service provided to people. This included mitigating any further risks relating to the health, safety and welfare of people. This was a breach of 17 (1) (2) (a) (b) (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Good Governance.

Daily observation and delivery of care records were not being recorded appropriately, this included personal care given, positional charts, any behaviour changes, nutrition and continence care. Care plans indicated that monitoring and observations should be carried out by staff however, this was not happening. Staff were recording 'care given as per care plan' and then naming the care plan. There was no specific information about care delivery or information about the wellbeing of the person. This meant the service was unable to monitor whether care was effective and responsive and person centred. The registered manager told us that the observation and monitoring records required improvement and staff would be receiving training in this area.

We found that the registered person had not maintained accurate records, complete and contemporaneous record of each person. This was a breach of 17 (2) (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Good Governance.

The provider had not submitted notifications of all incidents that affected the health, safety and welfare of people who use the service. We identified two issues that should have resulted in a statutory notification and one day where there was insufficient staffing on the 24 August 2015. Notifications tell us about significant events that happen in the service. We use this information to monitor the service and to check how events have been handled. The notifications that we had received did not always have sufficient information about the cause of injuries and incorrect notification forms had been used.

The registered provider provided additional information after the inspection in respect of Deprivation of Liberty safeguards. They told us 24 applications had been submitted on behalf of people on the dementia suite. Nine had been authorised with the others waiting for a representative to assess whether a DoLS would be appropriate. We checked the notifications that we had received and it was evident these had not been sent to us. The registered person has a legal responsibility to notify us of any authorisations.

The failure to send these notifications was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

People were encouraged to provide feedback on their experience of the service. The service had installed a computerised feedback system in the foyer. This enabled the service to receive regular feedback and identify issues that required attention. We were told this was fairly new and information was still being collated by head office in relation to the feedback. A relative told us they had raised concerns about the lack of activities. The registered manager acknowledged the shortfall but no improvements had been made to involve their relative or others living in the home.

The regional manager and regional managing director were aware of issues in the service as this had been fed back to them at a recent safeguarding meeting. They had produced an action plan to address the issues in addition to the action plan for CQC from our previous visit in June 2015. The managers had put in additional resources to the service to help the registered manager, which included a member of the provider's dementia team (three days a week), a peripatetic manager (five days per week) and a care quality facilitator providing weekly support. The regional manager was also attending the service two days a week.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing How the regulation was not being met: We found that the registered person had not ensured there were suitably qualified, competent, skilled and experienced staffing at all times. Regulation 18 (1).

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 How the regulation was not being met: People who use services were not protected against the risks associated with unsafe and inappropriate care because where people's needs had changed or an incident had occurred these had not been acted upon. Where health and social care professionals had requested action or provided advice this had not always been followed. Regulation 12 (1) (2) (a) (b) (c) (d) (e) (i)

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 How the regulation was not being met: People who use services and others were not always treated with respect and dignity. Regulation 10 (1) and (2) (a) and (b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment How the regulation was not being met: People who use services could not be assured that where an allegation of abuse was raised systems and processes were in place to

This section is primarily information for the provider

Action we have told the provider to take

prevent a further occurrence to ensure their safety. These were not being reported promptly to the registered manager or the local safeguarding team so that appropriate action could be taken to safeguard people. Regulation 13 (1) (2) (3) (4) (c)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance How the regulation was not being met: Effective systems were not in place to monitor and maintain the quality of the service and people were at risk of unsafe and inappropriate care. Regulation 17 (1) (2) (a) (b) (f)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care How the regulation was not being met: Care and support assessments did not include all the needs of people using this service, including for example, emotional, social and cultural needs. There was a lack of stimulation and activities for people Regulation 9 (1) (a) (b) (c)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent How the regulation was not being met: People were not being assessed in relation to their mental capacity to make decisions. Decisions regarding people's wishes with regard to their end of life care and support had been made without proper consultation and consent or followed where decisions had been made. Regulation 11 (1) (2) (3) (4) (5)

Regulated activity	Regulation

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance How the regulation was not being met: The registered provider had failed to ensure that accurate, complete and contemporaneous records were maintained in respect of each service user. This included a record of the care and treatment provided to the service user and decisions taken in relation to the care and treatment provided Regulation 17 (2) (c).
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 How the regulation was not being met: People who use services were not protected against the risks associated the administration of medicines. This was because there was a lack of guidance for staff on the safe administration to people and controlled medicines were not stored appropriately. Systems for ordering medicines was not robust. Regulation 12 (1) (2) (f) (g).

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents How the regulation was not being met: The provider had failed to notify us about incidents and allegations of abuse that affect the well-being of people. This included not informing us about insufficient staffing Regulation 18 (1) (2) (b) (e) (g) (i)