Bel-Air Care Limited

Oakleigh Care Home

Inspection report

Oakleigh Road
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Date of inspection visit:
06 November 2017
21 November 2017

Date of publication:
12 February 2018

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

The inspection took place on 6 and 21 November 2017 and was unannounced on both days. There were six people living in the home on 6 November and five on 21 November 2017. Four people were permanent residents at the home.

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

Oakleigh accommodates a maximum of 29 people in one adapted building.

The last inspection was in May 2017. At that time we found the provider was in breach of four regulations. Two of these Regulation 9 (Person centred care) and Regulation 17 (Good governance) were continued breaches since the previous inspection in November 2016. The other breaches were in relation to Regulation 12 (Safe care and treatment) and Regulation 11 (Need for consent). The overall rating was requires improvement, however, the service was placed in 'special measures.' We do this when services have been rated as 'Inadequate' in any key question over two consecutive comprehensive inspections. The 'Inadequate' rating does not need to be in the same question at each of these inspections for us to place services in special measures. In this case we rated the service inadequate in the 'well led' domain on two consecutive inspections.

On the first day of our inspection there was a registered manager in place. However, they told us they were leaving on 17 November 2017. They have made an application to cancel their registration with CQC. 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.

On the second day of our inspection there was no registered manager and the provider told us the ex-manager would be returning to work in the home as a senior care worker.

People told us there were enough staff to meet their needs. There was some disruption to the staffing as in the course of our inspection the registered manager and two senior care workers left. This would have left the service without enough staff to cover the rota. However, all three staff retuned to work at the home within a week. We were concerned the registered manager, provider and care staff had not identified the staffing situation as a potential safeguarding issue.

People who lived at the home told us they felt safe. Staff knew how to recognise and report abuse. The provider did not always work co-operatively with external agencies to ensure safeguarding concerns were fully investigated.

We found the provider had not taken suitable action to be sure agency care workers had been properly checked before they started working in the home.

For the most part people's medicines were managed safely. However, there was a risk of overuse of medication by staff who were not familiar with people's needs.

Risks to people's safety and welfare were not always well managed. The provider had addressed most of the issues with the environment which we brought to their attention at the last inspection. However, there were still concerns and some of these were repeated from the last inspection. For example, we found weekly checks on the fire systems had not been done. The design and décor of the building did not take into consideration the needs of people who lived at the home. This was the third consecutive inspection where we raised issues about the low levels of lighting.

Staff had received training on safe working practices and said they felt supported by the registered manager.

Overall, people were satisfied with the food and told us they were offered a choice of meals. We found the meals offered were not always nutritionally balanced.

The home was working in accordance with the requirements of the Mental Capacity Act.

People were supported to meet their health care needs and had access to the full range of NHS services.

People told us staff treated them with dignity and respect and we observed this during our visit. We saw staff supported people in a kind and compassion way.

People were at risk of not always receiving care which was appropriate to their needs. People were not supported to plan for their end of life care.
People were supported to take part in a variety of in house activities which took account of their individual interests.

There was a complaints procedure in place; none of the people we spoke with had any complaints about the service.

People who used the service had the opportunity to share their views by means of meetings and surveys.

The provider had systems in place to monitor, assess and improve the quality of the services. However, we found these systems were not operated effectively.

We found the provider was in breach of five regulations. Two of these Regulation 9 (Person centred care) and Regulation 17 (Good governance) were continued breaches since the last inspection. The other breaches were in relation to Regulation 13 (Safeguarding people), Regulation 19 (Fit and proper persons) and Regulation 18 of the Registration Regulations (Notifications of other incidents).

The overall rating for this service is 'Inadequate' Therefore the service will remain in 'special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made

significant improvements within this timeframe. If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

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 safe.

People told us they felt safe. However, when safeguarding concerns were raised the service did not always work openly with other agencies.

The required checks were not always completed for agency care workers which created a risk of people being supported by staff unsuitable to work in a care setting.

Risks to people's safety and welfare were not always managed well.

Overall people's medicines were safely managed. However, there was a risk of overuse of medication by staff who were not familiar with people's needs.

The home was clean but the décor was showing signs of wear and tear.

Is the service effective?

Requires Improvement

The service was not always effective.

The service was working in line with the requirements of The Mental Capacity Act which helped to ensure people's rights were protected.

Staff received training and support on safe working practices.

People were generally satisfied with the food and confirmed they were offered choices. People were not always offered nutritionally balanced meals.

People were supported to meet their health care needs.

The design and décor of the building did not take account of the needs of the people who lived there.

Is the service caring?

Good

The service was caring.

Staff treated people with dignity and respect.

Staff knew about people's needs.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

There was a risk people would not always receive care which was appropriate to their needs.

People were not supported to plan for their end of life care.

People know who to talk to if they had any concerns. There had not been any formal complaints about the service.

Is the service well-led?

Inadequate

The service was not well led.

The provider did not have effective systems in place to monitor, assess and improve the quality of the services provided.

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

Oakleigh Care Home

Detailed findings

Background to this inspection

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

The inspection took place on 6 & 21 November 2017 and was unannounced on both days.

On the first day the inspection was carried out by two adult social care inspectors and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. In this case our expert was experienced in the care of older people. On the second day two adult social care inspectors visited the home.

We carried out the inspection to check the provider had taken action to address the breaches of regulations identified in the last inspection report which was published in July 2017.

We spoke with six people who used the service, two care workers and the registered manager. We looked at three people's care records which included medication records. We looked at two staff files and other records relating to the day to day running of the home such as training records, maintenance records, meeting notes, survey results and audits. We observed people being cared for and supported in the communal rooms, observed the meal service at lunch time and looked around the home.

Before the inspection we looked at the information we have about the service including notifications sent to us by the registered manager. We contacted the local commissioning and safeguarding teams to ask for their views on the service.

On this occasion we did not ask the provider to complete a Provider Information Return (PIR). This is a form which gives the provider the opportunity to tell us about their service and any improvements they plan to make.

Inadequate

Is the service safe?

Our findings

At the last inspection in May 2017 we found the provider was in breach of Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. During this inspection we found the provider remained in breach of this regulation.

One person who used the service had a visual impairment and wore glasses all of the time. The assessment information which was completed in July 2017 identified they had a recent history of falls, however, their falls risk assessment which had also been completed in July 2017 stated they were at 'low risk' of falls. There was a note in the care file to leave their wall light on in their bedroom at night, as '[name] wanders during the night.' However, when we looked in their bedroom there was no wall light. We also noted the main lighting in this room was also poor and not suitable for someone with a visual impairment who was at risk of falling.

Following the inspection the provider sent us additional information included a copy of a care plan dated 7 October 2017 which stated the person should have their bathroom light left on at night. The provider also explained the person visited the home regularly for respite care and stayed in different rooms. In some rooms it was the wall light which was left on, in others it was the bathroom light. However, this information was not included in the person's care records.

We saw from the records this person had fallen in October 2017. This had happened at night and the person had gone to hospital by ambulance without a member of staff. This was because there were only two night staff on duty and there were no other arrangements in place to provide the person with support. We asked the registered manager what had been done to mitigate the risk of this person falling at night and they told us the night staff left the toilet light on with the door open ajar. They also said night staff checked their safety every hour at night, which was confirmed by the night check records. We were assured staff were taking action to mitigate the risk of further falls however, the person's falls risk assessment had not been updated following the fall in October 2017. This meant the provider had failed to maintain accurate and up to date records.

On 6 November 2017 we found the dishwasher was not working and when we checked again on 21 November 2017 it was still not working. On 27 November 2017 we received confirmation from the provider that it had been repaired.

On 6 November 2017 the registered manager was unable to confirm the Parker bath had been serviced. Annual servicing is required. On 21 November 2017 there was still no documentation to show a service had been carried out. On 27 November 2017 we received confirmation from the provider that the bath had been serviced on 24 November 2017. These matters should have been identified and dealt with by the provider's governance systems and processes.

We found the maintenance records were not up to date. The weekly fire alarm test, emergency lighting and visual fire extinguisher checks had not been completed since 3 October 2017. The maintenance person told

us they had been unable to carry out the checks because they were busy working at another home operated by the provider. During our inspection in November 2016 we identified a similar issue with weekly checks not being up to date. This demonstrated the provider had not learned lessons from previous inspections.

We looked at the emergency procedures. There was no personal emergency evacuation plan (PEEP) for one person who used the service. The person's care records showed they were living with dementia and would needed support from staff with their mobility.

There was no place of safety identified where people could be moved in the event of an emergency evacuation. The registered manager was unable to tell us where people could go if it was necessary to evacuate the building.

The registered manager told us the home had been without telephone and internet access for three days between 27 and 30 October 2017. There was no information in the business contingency plan about how to deal with a situation such as this. The provider was unable to demonstrate what measures they had put in place to mitigate the risk.

This was a continued breach of Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) 2014.

We looked at a selection of maintenance records and found checks on gas and water systems were up to date. Work had been carried out to check the safety of the electrical installations and hard wiring and a draft report had been issued by the contractor.

People who used the service spoke positively about the care they received and said they felt safe. One person said, "I am safe and well looked after, it's lovely." Nobody reported any incidents between people who used the service and or involving other people who lived at the home that particularly concerned them.

We saw information about safeguarding people from abuse was on display. However, we did note the services own policy referred to another service in the body of the text and not Oakleigh.

Staff understood the indicators of abuse and the registered manager knew how to report any concerns to the local safeguarding team. However, on the first day of the inspection visit the registered manager told us they were leaving on the 17 November 2017 and also informed us two of the senior care workers were leaving on the same date. We were concerned that neither the staff, the manager or the provider had seen this as a potential safeguarding issue as once they left the staff team would have consisted of three night care workers, one day care worker and one care worker who worked both nights and days. This meant there would not be enough staff to fully cover the duty rota to provide people with the care and support they required.

CQC was informed of a safeguarding concern in July 2017. We referred this to the local authority safeguarding team. The registered manager told us there had been a meeting with the person concerned and their relative. They said the provider should have the paperwork. The provider told us their consultant had dealt with it, however, the consultant no longer worked for the provider. The safeguarding authority informed us they had concluded, on the balance of probabilities, the allegation was substantiated. They noted the provider had not worked with them in a co-operative way to ensure the allegations were properly investigated without undue delay. This demonstrated you had failed to ensure systems were operated effectively to investigate allegations of abuse.

This was a breach of Regulation 13 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw the registered manager was holding money for some people who used the service. We saw receipts were obtained for any purchase made. We crossed referenced the money held for one person with the transaction sheet, no discrepancies were found or concerns identified. This showed us people were being protected from any financial abuse.

At the last two inspections in November 2016 and May 2017 the ground floor was the only part of the home occupied by people who used the service. During this inspection we found this had not changed. The passenger lift was not working. There was a stair lift to the first floor which was working. We found the provider had put a plastic coloured chain across the bottom of the stairs to deter people from going up. This type of barrier, which can be removed easily if necessary, is often used to deter people living with dementia from going into areas which may not be safe.
At the last inspection in May 2017 when we looked around the home we identified a number of risks to people's health and safety. These included concerns about the use of unlocked rooms on the first floor for storage, the storage of hazardous substances, unsecured windows in the conservatory, the absence of a bath thermometer to check hot water temperatures and torn floor coverings. During this inspection we found the provider had addressed these concerns.

We saw accidents were recorded. There had been three accidents since our last inspection in May 2017 and we did not identify any trends or patterns.

Everybody felt that the staffing levels were good one said, "There seem to be enough [staff], they can be busy, but they do their best." Most people felt there was a good response to the buzzer or when asking for assistance. One person said, "It all depends how busy they are, a few minutes."

Everybody felt that the level of regular staffing level was good with no use of agency carers one said, "I see the same ones most of the time."

On 6 November 2017 the registered manager told us they would be leaving the home on 17 November 2017 along with two of the senior day care workers. This would have left the home without any senior staff on days. We were concerned about the impact this would have on people who used the service. In addition to compromising the continuity of care they experienced, we were concerned about safety aspects, such as, the safe administration of medicines. Initially we were not satisfied with the provider's response; however, after requesting additional information we were assured suitable arrangements had been made to keep people safe.

To confirm this we made an unannounced visit to the home on 21 November 2017. We found a care worker in charge who was employed by a domiciliary care agency. We asked the provider if they had a contract with the agency for the supply of staff, they told us they did not. We asked the provider if they had received a profile for the agency worker to confirm all the required pre-employment checks had been carried out and they had the necessary training, skills and experience to take charge of the home. The provider told us they did not have a profile but had a file with information about the agency worker. The file did not contain documentation to confirm all the required pre-employment checks had been carried out and did not provide evidence of recent training on the safe management of medicines and food safety. The care worker told us they had only worked for the agency for a week. We observed the agency care worker administering medicines and preparing food for lunch. We were concerned the provider had not obtained assurance the agency worker had been properly vetted and trained. This was a breach of Regulation 19 of The Health and

Social Care Act 2008 (Regulated Activities) 2014.

This was not the first time the provider was in breach of this regulation. At the inspection in November 2016 we had concerns that robust recruitment procedures were not in place to protect people who used the service. Whilst we found improvements had been made to the way staff who were directly employed by the service were recruited we were concerned this had not been extended to the employment of agency staff.

Following our visit on 21 November 2017 the provider confirmed the registered manager and two senior care workers who had left on 17 November 2017 would be returning to work at the home. The registered manager would be working as a senior care assistant when their application to cancel their registration was completed. We confirmed this in a telephone conversation with the registered manager.

All of those who were given medication were happy that this was given in a timely manner. One person said, "I get my medicines at the same times each day, they are very strict about that."

When we inspected the service in May 2017 we found there was not always a member of staff on night duty who could administer medicines. This meant the service was in breach of regulation 12, safe care and treatment, in relation to medicines management. When we inspected the service on 6 November 2017 we found night staff had been suitably trained and were able to administer medicines during the night if this was necessary.

We found medicines were stored securely. The temperatures of the storage area and fridge were monitored to make sure medicines were stored at the recommended temperatures.

Senior care workers who administered medicines had received training and competency checks had been made to make sure they followed the correct procedures.

On 6 November 2017 we saw the senior care worker who was responsible for administering medicines checked the medicines to be given against the medication administration record. (MAR). This ensured the correct medicines were being given at the right time. Once the persons' medicines had been prepared they were taken to the individual, together with a drink. The senior care worker then stayed with the person until the medicines had been taken. We saw people being supported to do this in a kind and patient way. The senior care worker then signed the MAR to confirm the medicines had been given and taken.

We saw MARs had been consistently signed by staff to show medicines had been given as prescribed, including and prescribed topical creams or lotions. Protocols were in place for any 'as required' medicines which provided guidance for staff about the circumstances in which these medicines should be administered.

Some prescription medicines contain drugs controlled under the misuse of drugs legislation. These medicines are called controlled drugs. At the time of the inspection no controlled medicines were being held.

When we returned to the service on 21 November 2017 we identified a concern about the management of medicines. There was a senior care worker on duty, who was an agency member of staff and it was only their second day at the service.

One person had medicine prescribed to be taken 'as required' when they were very unsettled. There was a protocol in place to guide staff on the use of this medication. We saw from the records, for the past nine

days, it was usual for this medicine to be given in the late afternoon or evening. We saw the agency worker had administered this medicine on the morning of our visit at 9:15am. When we asked them how this person had been when they arrived for duty they said they had been fine. When we asked them why they had given the 'as required' medicine that morning they said, "[Name] was a bit agitated when I came in. I did try and calm her down but…." The other care worker on duty was a permanent member of staff. We asked them about the person in question and they told us, "[Name] has been fine this morning, no problems."

We looked at this person's daily records and there was nothing documented by the night staff or day staff about them being agitated that morning. When we looked at the stocks of the 'as required' medicine we found there was one less in the packet than there should have been. We brought this to the attention of the provider, who was not able to offer any explanation. We were concerned the senior care workers lack of knowledge and understanding of people who used the service may have led them to administer medication unnecessarily. This created a risk people would not always receive appropriate care and treatment. This was a breach of Regulation 9 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Everybody felt that the standards of cleanliness and hygiene were good. One person said, "There is always a vacuum going somewhere, there are no smells."

The local authority infection control team inspected the service in June 2016 and rated compliance at 95.25%. The manager told us the night staff carried out most of the cleaning. On 6 November 2017 we saw the registered manager had long, false nails on and three earrings in each ear. One pair of earrings was 'large squares.' This was in contravention of the services 'dress code' which stated, 'nail varnish and false nails are not permitted' and stated the only jewellery permitted was 'stud earrings and a wedding band.'

During this inspection we observed the floors and walls were clean, but the arms of the arm chairs looked dirty, and the communal areas were not very well lit. The bedrooms we saw looked clean and had personal touches in them.

Requires Improvement

Is the service effective?

Our findings

During the last inspection in May 2017 we saw the registered manager had assessed people's needs before they moved into the home to make sure staff would be able to meet their needs. During this inspection we were unable to assess this aspect of the service because there had not been any new admissions to the home. The local authority had placed an embargo on new admissions.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. None of the people living in the home had a DoLS authorisation in place, one had been applied for.

At the last inspection we were concerned the service was not always protecting people's rights and we found the provider in breach of regulation. During this inspection we found these concerns had been addressed.

Everybody responded positively about the level of training of the staff and the life quality they provided. One person said, "They are well trained, very pleasant."

During this inspection we looked at the training matrix which showed staff training was up to date. Training had been provided on subjects such as safeguarding, food safety, nutrition and hydration, infection control and dementia awareness. At the last inspection we were concerned staff had not received practical moving and handling training. During this inspection we found this had been addressed. The service had employed one new care worker since the last inspection. They had a previous qualification in health and social care. We saw they had completed induction training with an external training provider.

The registered manager told us they were up to date with staff supervisions and appraisals. This was supported by the records.

Everybody made positive comments about the cooking and the quantity of the meals. One person said, "Very good, plenty to eat, choice not bad at all, really good cook." All the people we spoke with said there were snacks and drinks available between mealtimes. One person said, "There is always plenty of juice or tea if you want it."

As part of the inspection on 6 November 2017 we observed the meal service at lunch time. The tables lacked tablecloths; there was a roll of kitchen paper for napkins. There were place settings, condiments and sauces. There was a hand-written menu on the wall with only one hot main course available; one person however was given an alternative hot meal. There were four diners and up to two carers in the room, only one person needed assistance. There was some good interaction between people living at the home. They were offered fruit juice and hot drinks during the meal. The carers did not appear rushed, and were involved in interacting with the diners giving individual attention when talking to them. The food looked reasonable and was served in good portions. People generally appeared to enjoy it, as most were eating with enthusiasm and two people cleared their plates. We overheard one person say, "I enjoyed it." One person did not eat the pie and said that this because she could not cut through the pastry, they declined help saying they were full up although we saw they had a pudding shortly after.

One care worker took a lead role in preparing homemade meals and baking. When they were not on duty other care workers prepared more convenience types of meals. For example, on the first day of the inspection there were ready made, supermarket meat and potato pies. We saw there was much more pastry than filling and one person did not eat theirs and told us they did not like the pastry. One person was having tinned curry and rice for their lunch. The person's records showed they liked tinned curry. One staff member told us they had tried to make their own but this had not been a big success. The pudding was apple strudel, which was also a supermarket own brand.

We questioned why there would be two pastry dishes on the menu for one meal. The registered manager told us the care worker who took the lead role for the catering had devised the menus with people who used the service. We saw food stocks were low. For example, there were four eggs, half a tub of cream, a polony, some salad, carrots, two cakes and three tubs of sandwich paste. The provider told us they had a food delivery every week from a well-known supermarket.

People told us they were given the amount of help they needed. One person said, "You get the help needed when you need it." People said the carers were good at responding to changes in condition, one said, "They check to see if they need extra help, like going to the hospital."

Everybody felt there was good access to other health care professionals a resident said, "They are good at getting them in."

We spoke with a visiting Community Matron and this was only their third visit to the service. They told us staff called them appropriately and followed instructions. For example, they had asked for a fluid chart to be put in place for one person so they could check they were getting enough to drink. Staff did this and they were able to establish the person's fluid intake was adequate.

In the three care records we looked at we saw people had been seen by a range of health care professionals, including GPs, opticians, district nurses and podiatrists. We saw from the records staff were vigilant and took timely action when people were unwell. We saw detailed records were made following any visits from health care professionals. We concluded people's health care needs were being met.

There was no evidence to show the design and décor of the premises had taken account of the needs of the people who lived there.

This was the third consecutive inspection when we identified the lighting levels in the lounge and dining room were dull with little or no light being emitted from the light bulbs. People with deteriorating eye sight need good lighting levels. Poorly illuminated living spaces can have an impact on people in a number of

ways. For example, it can make it harder for people to be independent and could increase the risk of falling.

At lunch time we observed the dining room was clean but wasn't welcoming. There wasn't any background music and the decoration was shabby and poorly maintained, there was water damage over the window. The overall impression of the home and the decorations was not very good; it looked tired and shabby and appeared to have a poor level of maintenance.

Good

Is the service caring?

Our findings

Everybody we spoke with was happy with the quality of the care given by the carers and the manner of their interactions with people. One person said, "They are very caring, they are making sure we are alright all the time." People all felt the staff took the time to listen and would try to act on concerns one said, "They always ask if I am alright, I find them very good."
All the people we spoke with felt they were treated with respect and that care was taken over their privacy and dignity. One person said, "They always make sure the doors and curtains are closed." People spoke positively about the support they received with personal care. One person said, "I can have a shower more or less when I want." Everybody felt that as far as possible they were supported in being as independent as possible. One person said, "They let you do as much as you can, they will help you if you want."

The interactions we saw between staff and people who lived at the home were all professional and at the same time warm, friendly and caring. Staff were all cheerful and friendly around people and nobody appeared to be uncomfortable with the staff being around them. We observed people were wearing appropriate, clean clothing which showed staff took time to assist people with their personal care.

We observed one care worker taking a group chair exercise activity helping one person individually while encouraging two others and then involving two in a ball catching and throwing session. The staff had time to sit and chat with people and there was some interaction between people who lived at the home.

We saw people's bedrooms were neat and tidy and personal effects such as photographs and ornaments were on display and had been looked after. This showed staff respected people and their belongings.

However, at lunch time we saw there were no serviettes available and people were being given sheets of paper towel. We also saw one person had a specialist spoon to try and assist them to eat independently. However, they were unable to use this effectively and needed support from staff to eat their meal.

We saw the care plans for people who used the service contained 'Life history' information and details of their interests and hobbies.

At the last two inspections the provider told us they had not made any specific adaptations in the preceding 12 months to meet the needs of people with protected characteristics which include race, religion, gender, marital status and disability. During the inspection we found people were treated with respect and we were satisfied they were protected from discrimination. The training matrix showed only two staff had undertaken training on equality and diversity. When we looked at the provider's equality and diversity policy we saw it only related to staff and made no reference to people who used the service. This should have been identified by the provider's governance systems.

Requires Improvement

Is the service responsive?

Our findings

At the last inspection we found there was a risk people's care was not always appropriate to their needs and the provider was in breach of regulation 9, person centred care. During this inspection the registered manager told us they had updated all the care plans. We saw care plans were in place which identified what people could do for themselves and what support they required from staff to meet their personal care needs. However, we concluded staff did not have had a pro-active approach to meeting people's needs or resolving issues with people. For example, we saw there was a 'behavioural chart' in place for one person and entries were all about them shouting for the toilet. No work had been completed with them to negotiate when it would be best to take them so staff could ensure there were two of them available to do this. For example, from the records we could see they usually needed the toilet after their breakfast.

We found people were not supported to plan for their end of life care. For example, one person's care plan contained information about them wishing to be cremated and where they wanted the service to be held. There were no further details about how they wished to be cared for at the end of their life.

We concluded the provider remained in breach of Regulation 9 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Three people we spoke with said they could remember looking around the home before they moved in. Another person said, "My son visited and thought it would be suitable." Everybody said they care staff knew about their care needs. One person said, "They know me very well, there are not many people here, so we get better treatment."

Only one person knew about their care plan. They said, "I have seen it, it's a big thing, we have talked about it recently." However, everybody felt they were actively involved in reviewing their care. Another person said, "We do talk about my care."

When we asked people who much they were involved in the running of the home we received a mixed response. One person said, "We don't have meetings, just general chats about likes and dislikes." Another said, "We have small meetings, there are not many here." There was a generally positive feeling about how the staff and management would respond to issues being raised outside of formal meetings. One person said, "If I had a suggestion I would put it to them, they'll see what they can do."

We saw there had been one meeting with people who used the service since our last inspection. This had taken place in September 2017 and the topics discussed included food and activities.

The majority were positive about the level and quality of the activities both one to one and in groups. They said they could choose whether to join in or not. One person said, "We chat, have a little concert, people come to sing to us, sometimes it's a surprise."

Nobody knew about formal complaints procedures this was not generally felt to be an issue as they did not want to make one, "No, I haven't [made a complaint], if I did they would get right on the job".

We looked at the complaints log and saw no complaints had been received since 2014.

At the time of our inspection no one living at the home needed support with accessible information. People's communication needs were assessed during their initial assessment.

Inadequate

Is the service well-led?

Our findings

In reaching our judgement of this domain we have taken into account the history of the service which has failed to achieve compliance with regulations over the last five consecutive inspections. We have also taken into account the fact that in addition to the continued breach of the regulations in relation to effective governance and person centred care our inspection identified three new breaches of regulation in relation to safeguarding, the employment of fit and proper persons and failure to notify CQC of a disruption to the service.

There was a registered manager in post on the first day of our inspection. However, they told us they were leaving on 17 November 2017 and two of the senior day care staff were also leaving on the same day. On 6 November 2017 the provider was unable to provide us with assurances they had made adequate arrangements to ensure people would be safe. In order to be assured there were suitable staffing arrangements in place we had to request additional information from the provider and made a further unannounced visit to the home on 21 November 2017. This demonstrated the provider was not managing risk effectively.

At the inspection in November 2016 the provider told us they had engaged the services of a consultant to help implement the required improvements. They said the consultant would undertake monthly audits to ensure the service was meeting people's needs and remained compliant with legislation. During the inspection in May 2017 we found there were no records of the consultant having visited Oakleigh since September 2016. Following the inspection in May 2017 the provider told us they had engaged a different consultant to support the registered manager. This was to ensure the required improvements were made so the service could be removed from special measures. During this inspection we found the consultant was no longer working for the provider and the registered manager told us the consultant had only visited Oakleigh once since the last inspection. There was only one provider visit recorded since our last inspection in May 2017. This had been carried out in October 2017.; The provider confirmed this was the only monitoring visit they had carried out. This demonstrated the provider had failed to ensure systems and processes were operated effectively to assess, monitor and improve the quality and safety of the services.

We found the registered manager continued to carry out a series of monthly audits. They confirmed the way they monitored the service had not changed despite the findings of the two previous inspections which showed the audits were not effective. During this inspection we again identified concerns which had not been addressed by the provider's governance processes. In addition, we found that although the provider had addressed some of the concerns raised at previous inspections they had not addressed them all and they remained in breach of a number of regulations. For example, at the last two inspections we raised concerns about low levels of lighting in areas used by people living at the home. During this inspection we found that had not changed.

Similarly during the last inspection we found safety checks were not always carried out in line with the provider's schedule. This included weekly checks on fire safety systems. During this inspection we found similar issues. We found the providers governance systems had not identified the Parker bath had not been

serviced and this was only addressed when it was raised by the inspectors.

We found other areas where the provider's governance processes had not been operated effectively to ensure people's safety. For example, there was no emergency evacuation plan for one person who was using the service for respite care. The provider's business contingency plan was not sufficiently detailed and did not include details of an alternative place of safety for people. The business contingency plan had no information about what to do in the event of loss of telephone and computer connection to the internet. The plan had not been updated to include this information after the service had been without telephone and internet services for 3 days in October 2017. In addition we found CQC had not been notified about this disruption to the service. This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009. We are dealing with this outside of the inspection process.

We concluded the provider's governance systems and processes were not operated effectively to assess, monitor and improve to service and to assess and mitigate risks. This was a continued breach of Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) 2014.

People spoke positively about the registered manager. One person said, "She [manager] comes in and sits in the room and chats." Everybody said there was a good atmosphere in the home. One person said, "The atmosphere is smashing, it's a home from home." Everyone we spoke with said they would recommend the home to other people.

People who used the service said they felt the home was well managed. One person said, "I do think it's well managed, very calm and quiet, everything is handy and quick."

Surveys had been given to people living in the home and/or their relatives in April 2017 to ask for their views of the service. The feedback showed people were satisfied with the service.

Staff told us they felt well supported by the registered manager and we saw staff meetings were held about every six months.

The registered manager held various events to raise money for the 'residents' fund.' We saw £21.30 had been spent on food for the tea time 'Halloween Party,' which had been held for people who used the service and their relatives. We asked the provider why this food was not paid for from their budget. They could not provide a satisfactory reason and just stated, 'It had always been done like this.' We also saw the 'residents' fund' had paid £5.10 to the local butcher. The registered manager told us this was for some tripe and potted meat dripping which one person who used the service had requested. We looked at that person's contract which stated, 'Fees include all meals, but do not include sweets.' This meant food should have been paid for by the service and not from the 'residents' fund.'

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The registered persons did not always work cooperatively with other agencies to ensure safeguarding concerns were thoroughly investigated. Regulation 13(3)