Joseph Rowntree Housing Trust

Hartrigg Oaks Domiciliary Care Agency

Inspection report

The Oaks, Hartrigg Oaks, Lucombe Way
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Ratings

Overall rating for this service	Good

Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

We undertook a comprehensive inspection at The Hartrigg Oaks Domiciliary Care Agency on 29 April 2016 and the inspection was announced. The provider was given 48 hours' notice because the location provides domiciliary care and extra care housing services and we needed to be sure that someone would be available to speak with us.

Hartrigg Oaks is a retirement village in New Earswick on the outskirts of the historic City of York. It is managed by the Joseph Rowntree Housing Trust. Hartrigg Oaks is registered to provide personal care to people in their own homes. It has its own dedicated care team who provide both home help and personal care otherwise known as domiciliary care. At the time of the inspection there were 12 people receiving care and support services.

The service had a registered manager, who at the time of our inspection was on a secondment to another service. There was an acting manager in post and the registered manager also attended during our inspection. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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.

The home was previously inspected in July 2013, and at the time was meeting all regulations assessed during the inspection.

People who used the service told us they felt safe and staff had received training in safeguarding people from abuse. They understood how to protect people from avoidable harm and how to report their concerns.

People's care plans contained consistent up to date information about their care and support including associated risk assessments and action plans. These were regularly reviewed and updated in line with the person's changing needs.

The service had sufficient experienced staffing in place to meet the care and support needs for people using the service. Recruitment processes were robust and ensured that staff were of suitable character to work with vulnerable adults.

The registered provider had robust policies and procedures for the safe handling of medication. People were supported to take their medication as prescribed. Medicines were stored securely, and there were systems in place to monitor the quantities of medications kept, and to ensure that care workers were competent in the administering process.

Staff had received training in the Mental Capacity Act 2005, and we saw the registered provider followed and worked within the basic principles of the Act.

People were supported with special dietary requirements and had their nutritional needs assessed. Where the registered provider had concerns about a person's weight, monitoring was carried out and people were supported by a range of health professionals to keep healthy.

We saw, and people told us that staff and others treated people in a caring way with respect and dignity. Care and support provided to people was person centred. This meant that people were actively involved in decisions about their health and care and that the care provided met with their needs and enabled them to be as independent as possible with a good, healthy quality of life.

People had access to a range of activities available in the wider Oaks village. Activities on offer ranged from access to the café restaurant to use of the gym and pool and trips out. Information was available for people to be involved, if they wished, in their community with meetings and events held that helped shape and improve the service.

The registered provider had a complaints procedure in place and people told us they understood how to complain and we saw that their complaints were acted upon.

People knew who the acting and registered manager were and told us that they found they were approachable and responsive to their concerns.

The registered provider undertook qualitative surveys with people receiving a service and employees. Feedback was analysed and we saw action plans and working groups were set up to respond to the feedback. All of this was used to help shape and improve the service people received.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

Care workers had received training in safeguarding and understood the signs of abuse to look out for. They knew how to report their concerns.

People were assessed and identified risks were documented with appropriate support plans in place to mitigate the risks. These risk documents and support plans were reviewed.

There were sufficient numbers of staff on duty who had the skills and knowledge to support people safely.

People's medicines were managed safely.

Is the service effective?

Good

The service was effective.

The registered provider ensured care workers received relevant training and completed courses to keep their knowledge and skills up to date.

Care workers and management understood the requirements of and worked within the guidelines of the Mental Capacity Act 2005.

People were supported with their nutrition and received assistance with food and drink.

People at risk of losing weight were closely monitored and where required support was available from other health professionals.

Is the service caring?

Good

The service was caring.

We observed care workers were caring and thoughtful, treating people with dignity and respect at all times.

People had their views listened to and they were involved with

developing their own care which met with their needs.

People's preferences were recorded and acted on by care workers.

Is the service responsive?

Good

The service was responsive.

The registered provider delivered care that was responsive to people's changing needs.

Care was planned and reviewed to encourage and maintain people's independence.

People had access and were encouraged to participate in a range of activities, which helped to avoid social isolation.

People were supported to transition between services and documents that went with them reflected their current needs.

Is the service well-led?

Good

The service was well-led.

The registered provider sought views and feedback from people and staff and the results were used to actively develop the service.

Quality assurance processes monitored the service provided to make positive improvements for the benefit of people's experiences of care.

People spoke positively about management and their involvement and support with the service.

Employees were kept up to date with information and best practice and they were supported to provide care and support in line with the latest regulations.

Hartrigg Oaks Domiciliary Care Agency

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 the 29 April 2016 and was announced. The provider was given 48 hours' notice because the location provides a domiciliary care service and we needed to be sure that someone would be in.

One adult social care inspector undertook the inspection. Before this inspection, we reviewed the information we held about the service, such as notifications we had received from the registered provider. The registered provider submitted a provider information return (PIR) prior to the inspection. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

We interviewed three care workers at the office and we spoke with the registered manager, the acting manager and the head of quality and compliance. We spoke with three people receiving a service and we looked at records that related to people's individual care; this included the care planning documentation for four people. We also looked at four care workers' recruitment and training records, care worker rotas, records of audits, policies and procedures, records of meetings and other records associated with running a community care service. We contacted the local authority for their feedback on the service. They told us they did not have any concerns regarding services provided.

Good

Is the service safe?

Our findings

People told us they felt safe and that care workers supported them in their homes. One person we spoke with said, "I do feel safe, they [care workers] are very observant, if they think something is wrong they will ask me; I feel very reassured that help is nearby should I need it."

People receiving a service were protected against the risks of potential abuse and bullying. Care workers had received training in safeguarding and understood how to recognise signs of abuse and report their concerns. The registered manager showed us a comprehensive policy and procedure about safeguarding adults from abuse and we saw it was written in conjunction with the local authority procedures for safeguarding adults from abuse. Both managers understood the requirement to report safeguarding concerns to the local authority and to the Care Quality Commission (CQC). The registered provider told us on their PIR, 'CQC notifications and safeguarding reports are logged centrally and reviewed by Directors on a monthly basis giving clear visibility at a senior level.'

We looked at people's care plans and we saw that these provided consistent up to date information about their care and support including associated risk assessments and action plans. Assessments of risk to people were carried out for a person's mobility, health, communication, personal care, nutrition, medication, infection control and psychological wellbeing and we saw these documented in people's care plans. An overview was provided that included the degree of risk, assessed as low, medium or high and we saw these were reviewed and updated every six months with the involvement of people, families and other health professionals. Environmental risk assessments had also been documented and these included access to people's homes and any equipment required. This information helped care workers plan and mitigate identified risks so that people received care and support in a safe managed way.

We saw from a person's care plan that the individual was independent with the administering of medication. However, the associated risk assessment advised the person was a 'Level 3; High risk'. We asked the acting manager about this and they told us the risk assessment reflected the risk associated with some medication that care workers administered. This was confusing for care workers and the manager told us, "The risk assessment form is being updated so that it is clear if a person needs full support or not and the new form will clearly identify any associated risk."

Where people had a lack of mobility, we saw the registered provider managed the associated risks of pressures sores using a 'Waterlow pressure risk assessment tool'. The Waterlow score (or Waterlow scale) gives an estimated risk for the development of a pressure sore for a person receiving a service. Where a person was deemed at risk, we saw care and support plans were in place and updated at least monthly. This meant the registered provider had procedures in place to minimise the risk of people developing pressure sores.

The acting manager monitored and investigated accidents and incidents within the service to ensure people were kept safe and any health and safety risks were identified and actioned as needed. When people had accidents, incidents or near misses, these were recorded and included details of the event, any witnesses

and any known cause. We were shown incident reports and saw these were investigated and agreed outcomes documented.

We looked at staffing levels across the service. The registered provider used an electronic staffing dependency tool to calculate the appropriate staffing levels to meet the dependency needs of the people using the service. We looked at staff rotas; we saw there were sufficient numbers of suitably trained and competent staff and that staffing levels were regularly reviewed. A care worker told us, "We have enough staff, we never use agency staff and if required we are offered extra hours to make sure calls are covered." Another care worker told us, "We are a strong team and we want the service to be the best for people so we always cover each other." One person who received a service told us, "I have never known someone not be available and I also have a personal alarm if I need assistance."

The registered manager told us and we saw that the registered provider had a range of ancillary personnel who supported management and care staff. This included domestic and kitchen employees and a maintenance team that worked across the organisation's group of services.

We checked the recruitment records for four care workers. We saw that an application form had been completed and two references had been obtained. We saw that one of the four files included a check with the Disclosure and Barring Service (DBS). The DBS carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults. We asked the acting manager about the date and number for the DBS checks for the other three care workers and they sent us this information after the inspection. These checks help employers make safer recruiting decisions and help to prevent unsuitable people from working with children and vulnerable adults. The registered manager advised us that staff shadowed experienced workers and had recruitment checks in place before being allowed to work independently. It was not always clear from care worker files that these checks had been undertaken and that the registered provider had received this information prior to the new employees starting work with people. The acting manager told us they undertook checks on staff files and would ensure the information was documented.

The registered provider had a medication policy and procedure in place and this followed guidance provided by, 'The National Institute for Health and Care Excellence' (NICE). We saw this was reviewed and updated annually. Staff told us additional training was provided when required. We looked at care worker files and saw they had received appropriate up to date training. A care worker we spoke with said, "We undertake safe handling of medication e-learning which is followed by three practical observations; if we are observed as competent we can then administer medication to people but if not we receive further training." Monthly documented competency checks were recorded and included observations on staff administering and recording medication to ensure staff remained competent to administer medication safely.

The acting manager told us that medication risk assessments were completed that determined the level of support required by a person. We saw that these were documented in people's care plans and that they were reviewed at least monthly. This ensured people retained their independence as much as possible with respect to the management of their medication. During our visit, we observed staff using personal protective equipment (PPE) such as gloves that reduced the risk of cross contamination. We saw that people were always asked if they were ready to take their medication and noted that the care worker gave the medication to the person concerned with a glass of water to help them swallow tablets.

Medication was kept in locked cabinets in people's homes. We saw medication administration records (MAR) charts were kept in people's homes and that staff did not sign the MAR chart until they had administered, or for people who self-administered, observed, the person had taken their medication.

We saw medication audits and quality assurance records; this evidenced that the medication policy and procedure was regularly monitored to ensure that people received the right medicines at the right time in line with current and relevant regulations and guidance.

The medication policy in place stated that when administering controlled drugs the MAR must be countersigned by a witness. We saw on one occasion, this was not the case. The acting manager said, "On that occasion two people attended the visit however only one person had completed their medication training and was able to sign the MAR." They told us, "We checked this was ok with our main office and they agreed as it ensured the person received their medication in a timely manner."
One person told us, "I don't remember everything, the staff are really good at prompting me to take my medication and they record it in my file," they said, "They re-order everything for me so I don't run out; it's one less worry for me."

Good

Is the service effective?

Our findings

People using the service said staff understood their needs and knew how to support them. One person told us, "I have regular carers, who I have known for many years; they support me like family, I am very lucky." Another person said, "They [care workers] are never rushed, they are friendly, professional and personable." A care worker told us, "We are fortunate to care for people on a regular basis, it helps us get to know them and we can tell when something is not quite right or there are changes in their well-being."

The registered provider told us they were implementing a new induction process that reflected the Care Certificate. The Care Certificate is an identified set of standards that health and social care workers adhere to in their daily working. We looked at staff files and saw the induction covered eight principles of care that included, duty of care, person centred approaches, positive behavioural support, equality and diversity, privacy and dignity, health and safety and infection prevention and control. This demonstrated how care workers were supported to understand the fundamentals of care.

The registered provider told us on the PIR, 'Full staff induction takes place which includes introduction to the environment and use of all equipment i.e. call system, fire arrangements, and individual associated equipment' and 'The training programme follows a blended learning approach with eLearning and face to face learning.' Care workers told us they felt the registered provider supported them to ensure they had up to date knowledge and skills to undertake their work. They told us and we saw from employment records they had attended an induction and additional mandatory training before working independently with people. This included safeguarding, moving and handling, dementia awareness, fire safety, diversity, equality, and The Mental Capacity Act.

Care workers we spoke with told us they were supported with training to meet people's specific individual needs. A care worker said, "People have an initial assessment and if they have specific needs such as Parkinson's or dementia we receive training so we can understand their needs and help them in the best way possible." The registered provider held regular awareness training in Dementia where staff could experience, 'What might it be like to experience dementia?'

The registered provider told us on the PIR, 'We use a key worker system to ensure that every person we support has a well matched key worker who can play a full role in planning and reviewing the individual's service." During their probationary period, we saw that new care workers undertook their first week shadowing a supervisor to ensure that they had the required competencies and that they were introduced to people to help create a match and relationship. This meant staff knew people and people knew the staff so that they received care and support appropriate to their needs.

Ongoing training was monitored electronically and staff had a training plan in place to ensure that they had the knowledge and skills required to effectively carry out their duties. Competencies were annually reviewed and records were kept in staff files. We saw documented observations were carried out, for example, on moving and handling and medicine management.

We looked at staff files and we saw that staff received quarterly structured supervisions, an annual appraisal and development review. Staff told us they had supervision meetings and we were able to view documented quarterly supervisions. We saw care workers had received some annual 'Performance Development Reviews' (PDR's) but that these were out of date. We asked the manger about this and they told us that they were implementing a new appraisal process, 'My Review' in May 2016. We were told this would improve support and appraisal of employees. This meant staff received effective support, induction, supervision, appraisal and training to support and care for people's needs.

Staff had received training and understood the requirements of The Mental Capacity Act 2005 (MCA). The 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 to receive care and treatment when this is in their best interests and legally authorised under the MCA. For people living in their own home, this would be authorised via an application to the Court of Protection. At the time of our inspection there were no authorisations in place however the registered manager was aware of changes (March 2014) in the case law around deprivation of liberty safeguards (DoLS)and understood when appropriate to do so authorisations may need to be submitted to the court of protection as a result.

We looked at people's care plans and saw people or their representatives were involved in their care planning. We saw people had provided signed consent to their care, support and information sharing and that this was dated. Consent to agreed support with medication was also signed and dated.

People were supported to maintain good health. Care plans we looked at included information on a person's health, their eating and drinking, food supplements, and nutrition and hydration. We saw care plans contained detailed information to ensure people were not at risk of malnutrition. Where risks were identified for a person we saw the registered provider used a 'Malnutrition Universal Screening Tool' ('MUST') to document this. These were reviewed monthly and where risks were identified, we saw the person's care and support plan had been updated. A person told us, "I have lost weight recently and I am slow to put it back on; the staff are monitoring it, they weigh me every day and speak to me about my diet." Another person told us "I used to work in catering and I have my meals delivered," they continued, "The food is prepared in the kitchen in the residential home and I have to say that it is very well presented with lots of choice," and, "Staff are always around to help me and they serve it up onto a plate for me." A care worker said, "We record people's weight using charts and if things do not improve we may contact a GP or dietitian if required."

The registered provider told us on the PIR, "The care planning approach supports people to identify their preferred outcomes, for example nutritional support to achieve and maintain weight gain. We support people to make healthy, nutritious food choices and an individual nutritional risk assessment is completed where appropriate. Where people require support to meet their nutritional needs this is planned with them."

Good

Is the service caring?

Our findings

People we spoke with told us they were happy with the care and support they received. Comments included, "They [staff] are incredible, they just get it right," "I feel very lucky to receive such good care" and "We are treated with such dignity; staff are so respectful."

We observed that staff knew people well and addressed them in line with their preferences. People responded and talked about their care workers as though they were part of their family. One person told us, "I was successful in business and I liked to be addressed as [name]." We observed care workers knocked and called to the person, waiting for a response before they entered their homes.

The registered manager told us, "Relationships between staff and people are reviewed to ensure they are positive ones and action is taken if relationship not working." The registered manager told us they tried to match staff and people to meet their needs and interests and that this was reviewed. From our observations, we saw that people reacted in a positive manner, often smiling when friendly faces approached.

We asked staff how they knew people, their needs and preferences. They told us "We have regular rotas and we are not rushed on a call to go somewhere else so we can spend time getting to know people, their likes and dislikes." Another care worker told us, "Care plans are a very good starting point; they contain up-to-date general information and information about a person's history." We looked at the files in people's homes. They included a, 'What's Important to Me' section of the care plan, a photograph of the person, details of their key worker, and an activities record. We saw this was used to develop a personalised service for people.

Staff we spoke with told us that people, their families and advocates were involved with their care and support planning. We saw from care files that there was documented communication between the registered provider, people, their families and other health professionals. People told us their views were listened to and that they were involved with developing their own care and that it met with their needs.

Discussions with staff revealed there were no people living at the service with any particular diverse needs in respect of the seven protected characteristics of the Equality Act 2010 that applied to people living there: age, disability, gender, marital status, race, religion and sexual orientation. We were told that some people had religious needs but these were adequately provided for within the service and by people's own family and spiritual circles. We saw no evidence to suggest that anyone that used the service was discriminated against and no one told us anything to contradict this.

The registered provider told us on the PIR, 'Through recruitment, induction, ongoing training and supervisions, we focus on dignity, respect and kindness.' Staff told us they understood what was meant by 'confidentiality'. One person told us, "It is a real community and people know each other quite well," they said, "It is therefore very important to ensure we maintain peoples confidentiality at all times and that we do not discuss or talk about people in front of, or with others, apart from those directly involved with their care." We saw that when a person was away from their home the registered provider had a process in place

to record their agreement to share this information with other people. This respected people's confidentiality and meant their wishes and preferences were respected and only shared if agreed by the individual.

We spoke with staff and they confirmed to us that they had a good appreciation of what was meant by treating people with dignity and respect. One care worker told us, "I would always ensure any personal care was in line with a person's wishes and I would treat them how I would want to be treated in my own home." They continued, "As long as a person was safe I would ask them if they needed time on their own, encourage them to assist with the task, if they were able to do so and I would make sure towels and dressing gowns were ready to protect their dignity.

We saw people had a completed, 'Do Not Attempt Cardiopulmonary Resuscitation, (DNACPR) on file. We saw these were available at the front of peoples care plans with the rationale for this decision. DNAR orders are a decision made in advance should a person suffer a cardiac or respiratory arrest about whether they wish to be resuscitated. People were supported to make their preferences for end of life care known and these were recorded in their care plans.

Good

Is the service responsive?

Our findings

People we spoke with told us the service was responsive to their individual needs. One person told us, "I have just returned from some time in hospital and the care workers have been fantastic in helping with my rehabilitation." They said, "They [care workers] worked with me to help in the morning when I needed lots of assistance but this has now improved and I can now get up on my own because of the way staff responded to my needs."

The registered provider told us people receiving a service in their homes were allocated a nominated individual known as a 'key worker' and a support assistant to support all aspects of their care delivery, choices and relationships with the person. We looked at a recent survey and saw that 90% of people who responded 'strongly agreed' or 'agreed' that they knew who their key worker was and 100% of people who responded 'strongly agreed' or 'agreed' that staff knew them as individuals and understood what was important to them. This meant people, their family members and health care professionals had a point of contact for all communication about and with the individual. The key worker provided people with an introduction to the service and put together the person's initial care planning document. We saw these included people's input and were person centred. They contained a section on 'What's Important to Me' that recorded personal history, personal preferences, interests and aspirations. Information was documented to help people stay in touch with their friends and family, to help them with communication and identified if they had a hearing aid. We saw one care plan included information on a person's preferences with personal care that stated, 'I wash and dress myself but I have help showering."

People told us there was always support available even outside of usual office hours. We saw people had the use of a call button. One person told us "I don't use it very often but when I have done in the past, someone came to check on me and I didn't have to wait long."

The registered provider told us on the PIR, "The philosophy of Hartrigg Oaks is to promote independence and support residents to remain at home in their own bungalow for as long as possible." A care worker said, "The service is all about the people and what they want, we are here to support them and help them to live independently."

Care was centred on the individual and their needs. A section in the care plans included information about the type of care provided, the reason for the care, intervention required, the service arrangement and we saw this was signed and reviewed at least every six months. An example included a person who required assistance with the management of daily activities due to ill health. Intervention included assistance with housework and shopping and the service had introduced additional cleaning and laundry support. This was reviewed as the persons health improved and interventions reduced to promote the persons independence.

People who lived in their own homes had access to a range of activities and events that were on offer in the main building attached to the residential home. These activities included games nights, trips out, access to a music hall, and access to the café and restaurant where they could meet up with family and friends for a sociable lunch. Information was available for people to be involved, if they wished, in their community with

meetings and events held that helped shape and improve the service. The acting manager told us access to activities helped people to avoid social isolation if that was there choice.

The registered provider had a complaints policy. People we spoke with told us they knew how to complain. One person told us, "I only have one radiator and I have mentioned that but really I don't have many complaints." Another person said, "Staff regularly ask me if I am happy with my care and support, I think if I had a complaint they would look into it and I am sure they would find a solution." A member of staff told us, "People have information in their care plans about how to complain and we also ask them if they are happy with everything and encourage verbal feedback." We saw that information from complaints and compliments was collated and fully investigated as part of quality management. The registered manager told us this helped with future learning and improvement.

The registered provider worked with a range of health professionals and others to ensure people received a smooth transition between services. The registered manager told us the service was part of the larger, Joseph Roundtree Housing Trust service and as such people transitioned between their own homes and the residential service when the need arose. They told us, "Transfer of a resident from the wider Hartrigg Oaks community into The Oaks [residential home] is supported by the on-site Community Care and Support Team; information is shared to ensure smooth transition with the staff teams working together."

Good

Is the service well-led?

Our findings

There was a registered manager. The registered manager was on secondment to a different service in the organisation and there was an acting manager in place. During our inspection, we were supported by both managers, the head of quality and compliance and a community care and support worker. People we spoke with provided positive feedback about the leadership and there was a high degree of confidence in how the service was run. Comments we received about the registered manager included, "Really lovely," "Down to earth," "Supportive," and "Like a friend."

Care workers told us they would not hesitate to raise any concerns if they suspected bad practice. One care worker told us, "I wouldn't hesitate in whistleblowing any bad practice." Another care worker told us, "If we think something isn't right you can speak to the manager and they will address the concerns and will always try and support you." A person told us, "They [Management] are very friendly and easy to talk to." We were told there was a supportive culture in the organisation for employees and that the service was driven around individual people receiving care and support.

There was a clear management structure in place and staff had an understanding of their roles and responsibilities. The acting manager told us, "There is support from senior managers from the wider organisation who are available for advice and support as required." A care worker told us, "Directors are known by their first name, they are involved in the services; it is a nice job and a nice place to work."

The registered provider told us on the PIR," The registered manager submits all Care Quality Commission (CQC) notifications and safe guarding referrals and records them on an internal system that is reviewed by senior managers and directors." We spoke with the registered manager who confirmed they knew about their registration requirements with the CQC and were able to discuss notifications they had submitted. This meant they understood and followed the conditions of their registration.

Care workers were regularly observed for best practice when they worked with people and we saw those observations included daily activities such as moving and handling and medication administration. This was documented and we saw outcomes were discussed and documented with care workers during staff supervisions. Care workers were provided with feedback indicating what they had done well and what needed improvement. Where practice was deemed to require improvement the acting manager told us they initially used it as a learning opportunity and provided additional support and training until the member of staff was deemed competent.

The registered provider kept employees up to date with information and best practice and we saw from the minutes of team meetings that these topics were included. Employees had access to policies and procedures that were reviewed in line with changes in legislation to underpin service quality and safety. These included procedures related to environmental safety, staffing and care practices. Staff were required to read policies and sign them to evidence their understanding of them.

The registered provider showed us a new draft annual survey that had been implemented to gauge people's

feedback on the service they received. The survey analysed the results using the five CQC lines of enquiry; safe, effective, caring, responsive and well led. Where respondents disagreed, they were asked to comment as to the reason why. The survey was summarised and for example, we saw feedback was 100% positive in response to people believing staff knew them as an individual and that staff understood what was important to them and that they felt staff were caring and supportive. We saw the survey identified 50% of people were neutral or disagreed with the statement, 'Staff help me arrange to see a doctor or dentist if needed.' As a result of this feedback we saw the registered provided had made recommendations to set up a working group to include residents to clarify their opinions further and provide further actions and assistance for people to see a dentist or doctor. This meant the registered provider had taken steps to make sure that, people were involved in making decisions and planning their own care, that they felt listened to, respected, and had their views and wishes respected.

We saw the registered provider had conducted a survey with its employees that included a feedback and action booklet. They had produced an update on the progress of the action plan that included 'You said' and 'We did'. Along with documented team and individual, 'Commitments to making a difference', the consultation showed that the registered provider consulted, analysed and acted on the views and opinion of its employees in shaping the service.

People, staff and others told us and we saw from care plans that people received multi-agency support and care from other health professionals. The registered provider told us on the PIR submission, 'The Oaks has a good relationship with the local GP Practice, which includes weekly attendance on site (plus emergency call out) and as appropriate the care home has involvement with District Nurses, CPNs, Consultant Psychiatrist, Speech & Language Therapist and Funded Nurse Care Assessors.' This meant people received holistic care that met with their changing needs and preferences.

The registered provider had a statement of purpose. We saw that this included visions and values of the service and that a programme of quality assurance upheld these. Monthly audits were undertaken that lead to a quarterly evaluation of the service. We saw this resulted in action plans being implemented for improvement where targets were not met. We saw the action plan was reviewed as work in progress and included recommendations, evidence of action in progress, action complete and managers monthly check list. We asked care workers if quality assurance helped to drive improvement and they told us "If a mistake is made then we do learn from it." Another care worker said, "Yes I think so, there is learning from most events and it helps improve the service."