PWC Care Limited

Oak Tree House Residential Care Home

Inspection report

Oak Tree House, Oak Tree Estate
Station Road, Preston
Hull
Humberside
HU12 8UX

Tel: 01482899169
Website: www.pwccare.co.uk

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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

This inspection took place on 5 April 2017 and was unannounced. At the last comprehensive inspection of the service in February 2016 we rated the home as Requires Improvement due to breaches in Regulation 12: Safe care and treatment (because of our concerns about poor infection control), Regulation 15: Premises and equipment (due to poor maintenance of the premises) and Regulation 17: Good governance (due to concerns about quality assurance and the unavailability of some records).

At this inspection we found that improvements had been made to the cleanliness and safety of the premises and that quality assurance systems were more effective. This meant that the breaches of regulation identified at the last inspection had now been met. However, there had again been a delay in the registered provider arranging for the gas safety systems to be serviced. We will address this matter outside of this inspection process.

The home is registered to provide accommodation and care for up to 20 older people, including people who are living with dementia. On the day of the inspection there were 15 people living at the home. The home is situated in Preston, a village in the East Riding of Yorkshire but also close to the city of Kingston upon Hull. The premises are on two levels and the first and second floors are accessed by use of a stair lift.

The registered provider is required to have a registered manager in post and on the day of the inspection there was a manager who was registered with the Care Quality Commission (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.

People were protected from the risk of harm or abuse because there were effective systems in place to manage any safeguarding concerns. Staff were trained in safeguarding adults from abuse and understood their responsibilities in respect of protecting people from the risk of harm.

There was evidence that the registered provider was working within the principles of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). Staff had received training on these topics and understood their responsibilities.

Care plans were a good reflection of people's individual needs and how these should be met by staff. There was a lack of consistency in recording on monitoring charts. This had not resulted in any harm to people but had the potential to do so. We observed that the registered provider discussed the importance of accurate recording with staff on the day of the inspection.

People's family and friends were made welcome at the home. A variety of activities were provided and people were encouraged to take part.

There were recruitment and selection policies in place and these had been followed to ensure that only people considered suitable to work with vulnerable people had been employed. On the day of the inspection we saw that there were sufficient numbers of staff employed to meet people's individual needs.

Staff told us they received the training they needed to carry out their roles effectively and confirmed that they received induction training when they were new in post. Staff told us that they were well supported by the registered manager.

Senior staff had received appropriate training on the administration of medication. We checked medication systems and saw that medicines were stored, recorded and administered safely.

People who lived at the home told us that staff were caring and that they respected people's privacy and dignity. We saw that there were positive relationships between people who lived at the home and staff, and that staff had a good understanding of people's individual care and support needs.

People told us that they were satisfied with the food provided. We saw that people's nutritional needs had been assessed and individual food and drink requirements were met.

The registered manager was aware of how to use signage, decoration and prompts to assist people living with dementia in finding their way around the home and some progress had been made in providing these.

There were systems in place to seek feedback from people who lived at the home and their relatives. People told us they were confident their complaints and concerns would be listened to. Any complaints made to the home had been investigated and appropriate action had been taken to make any required improvements.

Quality audits undertaken by the registered manager were designed to identify that systems at the home were protecting people's safety and well-being.

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.

Staff had received training on safeguarding adults from abuse and understood their responsibility to report any incidents of abuse.

Staff had been recruited following the home's policies and procedures and there were sufficient numbers of staff employed to ensure people received safe and effective support.

Staff adhered to the home's medication policies and procedures and this meant people who lived at the home received the right medication at the right time.

Is the service effective?

Good

The service was effective.

Staff undertook training that gave them the skills and knowledge required to carry out their roles effectively.

People's nutritional needs were assessed and we saw that meals were prepared to meet people's individual dietary requirements.

The principles of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) were being followed. People's physical and mental health care needs had been met.

Is the service caring?

Good

The service was caring.

We observed positive relationships between people who lived at the home and staff.

People's individual care and support needs were understood by staff, and people were encouraged to be as independent as possible, with support from staff.

We saw that people's privacy and dignity was respected.

Is the service responsive?

Good

The service was responsive to people's needs.

People's care plans recorded information about their support needs and how these should be met by staff. Care provided was mostly person-centred, although monitoring charts had not been consistently completed.

Visitors were made welcome at the home and activities were provided.

There was a complaints procedure in place and people told us they were confident any complaints would be listened to.

Is the service well-led?

Good

The service was well-led.

There was a registered manager in post. They had submitted notifications as required by legislation.

Staff told us that they were well supported by the registered manager and senior managers within the organisation.

Audits were being carried out to monitor the effectiveness of the service. There were opportunities for people who lived at the home and other people involved in their care to give feedback about the service provided.

Oak Tree House Residential 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 checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection took place on 5 April 2017 and was unannounced. The inspection was carried out by one adult social care (ASC) inspector.

Before this inspection we reviewed the information we held about the home, such as information we had received from the local authority and notifications we had received from the registered provider. Notifications are documents that the registered provider submits to the Care Quality Commission (CQC) to inform us of important events that happen in the service. The registered provider was asked to submit a provider information return (PIR) before this inspection and it was returned to us within the required timescale. The PIR is a form that asks the registered provider to give some key information about the service, what the service does well and improvements they plan to make.

During this inspection we carried out observations using the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not communicate with us.

Healthwatch had carried out an Enter and View visit in March 2016 and the comments in their report were positive. Healthwatch is an independent consumer champion created to gather and represent the views of the public.

On the day of the inspection we spoke with three people who lived at the home, two visitors, two members of staff and the registered provider; the registered manager was on holiday. We looked around communal

areas of the home and some bedrooms, with people's permission. We also spent time looking at records, which included the care records for two people who lived at the home, the recruitment records for two members of staff and other records relating to the management of the home, such as quality assurance, staff training, health and safety and medication.

Good

Is the service safe?

Our findings

At the last inspection of the service we had concerns about the safety of the premises and equipment. We found that the gas safety certificate had expired, the required repairs had not been carried out on the stair lift and the downstairs bathroom was recorded as 'out of action' as the bath hoist was broken and needed to be replaced. This was a breach of Regulation 15: Premises and equipment of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We received information from the registered provider following the inspection to confirm that the required works to the stair lift had been carried out. At this inspection we saw there was a service contract in place and the stair lifts had been serviced in November 2016. We looked at other service certificates to check that the premises were being maintained in a safe condition. There were current maintenance certificates in place for the fire alarm system, fire extinguishers, portable electrical appliances, the electrical installation and hoists and slings. There was a fire risk assessment in place. Weekly in-house checks of the fire alarm system had been carried out, as well as monthly fire drills. This showed us that the previous breach of regulation 15 had now been met.

However, we found that the gas safety certificate had expired; on this occasion it expired four days before the inspection. The registered provider told us that this work was planned and we received confirmation following the inspection that the work had been carried out. Although the required service certificate was now in place, this was a repeat of shortfalls found at previous inspections when we found the gas safety certificate had expired. We will address this matter with the registered provider outside of this inspection process.

At the last inspection of the service we had concerns about the prevention and control of infection. We found that the laundry room was difficult to keep clean as the tops of two boilers in the middle of the laundry room were rusty. The bath seat in one of the bathrooms was worn and therefore difficult to keep clean. Staff had not completed training on the prevention and control of infection. This was a breach of Regulation 12: Safe care and treatment of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we walked around the premises and saw improvements had been made to hygiene standards. The tops of the boilers in the laundry room had been painted and could be washed. The bath seat in question had been painted so it could be cleaned. Both of these were clean on the day of the inspection. The laundry room was divided into 'clean' and 'dirty' zones and the walls and floor were easily cleanable. Personal protective equipment (PPE) was readily available for staff and disinfecting hand wash was available at various areas throughout the home. An infection control audit had been carried out and the identified actions had been completed. Staff had undertaken training on the prevention and control of infection. The home had achieved a rating of 5 following a food hygiene inspection undertaken by the local authority Environmental Health Department. The inspection checked hygiene standards and food safety in the home's kitchen. Their report recorded, 'Very good systems are being implemented by the staff.' This showed us that the previous breach of regulation 12 had now been met.

People who lived at the home told us they felt safe living at Oak Tree House. One person said, "Yes, I feel safer here than I did at home" and another told us, "There are staff around during the night." Staff described to us how they kept people safe. They said they made sure there were no hazards around the home, made sure people used any mobility equipment they needed, ensured fire doors were closed and asked any visitors to the home for identification.

Information to advise staff how people should be assisted to mobilise was included in care plans; this included any equipment that was required and how many staff would need to assist with each activity. On the day of the inspection we observed staff using mobility equipment safely to move people. A member of staff told us they were the moving and handling champion and that their role included showing staff how to move people safely, and observing staff practice. We saw that people also had equipment in place to protect them from the risk of developing pressure sores.

Staff told us that they completed training on safeguarding adults from abuse and this was confirmed in the training records we saw. Staff were able to describe different types of abuse, and the action they would take if they became aware of an incident of abuse. Staff told us they knew the signs to look out for and, because they knew people very well, they would recognise if something was wrong. They said they would report any concerns to the registered manager and were certain the issue would be dealt with professionally. Staff told us they would not hesitate to use the home's whistle blowing policy if they had cause to, and they were confident any information shared by them would be treated in confidence.

The registered provider told us they used the safeguarding consideration tool introduced by the local authority. This helped staff measure the level of risk involved and whether an alert needed to be submitted to the local authority. There had been no safeguarding incidents during the previous 12 months; the registered provider told us that any completed alerts would be stored centrally but also in people's care plans.

We checked the recruitment records for two members of staff and these records evidenced that an application form had been completed, references had been obtained and checks had been made with the Disclosure and Barring Service (DBS). The DBS carry out a criminal record and barring check on individuals who intend to work with vulnerable adults. This helps employers make safer recruiting decisions and helps to prevent unsuitable people from working with vulnerable adults. Documents to confirm the person's identity had been retained.

On the day of the inspection the staff on duty included the registered provider (who was covering for the registered manager), one senior care worker, two care workers and a cook. In the afternoon there was also a domestic assistant on duty. The staff rotas showed there were occasional days when there was only one care worker on duty. The registered manager assured us that these shifts were covered either by the registered provider, the registered manager or by a member of ancillary staff 'acting up' as care worker. They agreed that this should have been recorded on the staff rota. Most people who lived at the home told us that there were sufficient numbers of staff on duty and that staff responded to call bells promptly. We concluded that there were sufficient numbers of staff on duty to meet people's needs.

Assessment tools had been used to identify if there was any level of risk, such as the Waterlow assessment tool in respect of pressure area care, a pain assessment and the malnutrition universal screening tool (MUST). When risks had been identified, there were appropriate risk assessments in place that detailed the identified risk and the action that needed to be taken to minimise the risk. Risk assessments were reviewed on a regular basis to ensure they remained relevant and up to date.

Care plans recorded possible behaviours that might challenge the service. We observed that if people became anxious or distressed, staff were skilled in distracting and calming them. Staff told us that they never used physical restraint.

There was a contingency policy in place that included advice for staff on how to deal with emergency situations. In addition to this, each person had a personal emergency evacuation plan (PEEP) in place. PEEPs record the support each person would require to leave the premises in an emergency, including any equipment that would be needed and how many staff would be required to assist.

There was a medication policy in place and we observed that medicines were appropriately ordered, received, recorded, administered and returned when not used. People told us they had no concerns about the management of medicines and that they received their medicines on time. There was evidence that staff who had responsibility for the administration of had completed appropriate training.

Medicines were supplied by the pharmacy in blister packs; this is a monitored dosage system where tablets are stored in separate compartments for administration at a set time of day. Medicines were stored securely in a medicines trolley that was fastened to the wall. Controlled drugs (CDs) were also stored securely. CDs are medicines that require specific storage and recording arrangements. We checked a sample of entries in the CD book and the corresponding medicine and saw that the records and medicine held in the cabinet balanced.

We saw that the temperature of the medicine fridge and the medicine area were checked and recorded to ensure that medicines were stored at the correct temperature. Medicines that needed to be returned to the pharmacy were stored securely and recorded in a returns book. In most instances there was an audit trail to ensure that medicines prescribed by the person's GP were the same as the medicines provided by the pharmacy. There were a small number of occasions when medication had been prescribed mid-cycle and the prescription was sent directly from the GP surgery to the pharmacy. The registered provider told us they would ask for a copy of the prescription in future so they could check the correct medicines had been supplied.

We looked at MAR charts and found that they were clear, complete and accurate. There was a laminated sheet for each person who had a MAR chart in place and this included the person's photograph, their date of birth and any known allergies. This helped new staff to identify people when they administered medicines. We saw only one gap for the administration of one person's eye drops and concluded this had not caused the person harm.

We saw that accidents and incidents were recorded appropriately. The registered provider told us that accident and incident reports were handed to the registered manager for checking, and that they would take any immediate action needed, such as contacting the person's GP. The report would then be stored in the person's care plan. They said the accident or incident would also be discussed at the staff handover meeting so staff were aware that the person needed to be observed. However, there was no overall analysis to help the registered provider identify any patterns that were emerging or any further action that needed to be taken in respect of a person's increased care needs. The registered provider agreed that this analysis would take place in future.

Weekly in-house checks of the fire alarm system had been carried out, as well as monthly fire drills. We looked at service certificates to check that the premises were being maintained in a safe condition. There were current maintenance certificates in place for the fire alarm system, fire extinguishers, portable electrical appliances, the electrical installation, the stair lift and hoists and slings. There was a fire risk

assessment in place.

Good

Is the service effective?

Our findings

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 MCA 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. We saw that a person's capacity to make decisions and consent to their care was recorded in their care plan, and any best interest decisions made on a person's behalf were also recorded. The staff who we spoke with understood the principles of this legislation.

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. The application 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. We saw that the registered provider had submitted applications to the local authority for consideration when required.

People told us that staff asked for consent before they started to assist them. One person said, "Staff always check if it is okay." Staff told us they always consulted people and 'reassured people all of the time'. They explained how they helped people to make day to day choices. They said they gave different options and might show people a choice of clothes to help them make a decision about what to wear. One member of staff said, "We can't choose for them." Staff said they would also check a person's care plan in respect of their likes and dislikes, and would speak to the person's family to gain more information.

Staff told us they had completed an induction programme. One member of staff said this helped them to understand their role and added, "I felt I could approach staff to ask questions if I wasn't sure about anything." The induction checklist recorded that the structure and organisation of the business, a tour of the home and a job description were discussed as well as core training topics. Following induction training, staff had a competency check to measure their understanding of their training.

75% of staff had achieved a National Vocational Qualification (NVQ) or equivalent at Level 2 or 3. The registered provider told us that, if new employees already had a NVQ or equivalent, they had to complete the home's induction programme but were not required to complete the Care Certificate. People new to the caring profession were expected to complete the Care Certificate and training records showed that five staff had completed the Care Certificate. This ensured that new staff received a standardised induction in line with national standards.

Staff told us they were happy with the training they received. The registered provider considered safeguarding adults from abuse, first aid, infection control and moving and handling to be essential training, and records showed that staff had completed this training. In addition to this, care staff had completed training on fire safety, medication, equality and diversity, dementia and person-centred care. The quality assurance report recorded a summary of the staff training completed during 2016 / 17 and this showed that

staff carried out regular refresher training.

The registered provider told us that all staff had an annual appraisal and that they aimed to hold supervision meetings every three months. Staff told us that they had supervision meetings with a manager and that they felt they were well supported. One member of staff said, "I have just become a senior carer. I've had lots of support" and another said, "I get good support from the registered provider and the registered manager. I can ask them anything."

People told us that they could see their GP and other health care professionals whenever they needed to. One person told us they regularly saw a chiropodist. Any contact with health and social care professionals was recorded in people's care plans.

People had hospital passports in place. These are documents that people can take with them to hospital appointments and admissions when they are not able to communicate information about their care and support needs to hospital staff. They provide hospital staff with information about the person to enable them to meet their needs.

We saw that people had a nutritional screening tool in place and that they were also weighed regularly. People who could not be weighed had their BMI checked to ensure they were not at risk of malnutrition or weight gain. Referrals had been made to dieticians or the speech and language therapy (SALT) team when concerns about nutrition or swallowing / choking had been identified. Advice from these health care professionals had been incorporated into people's care plans and we observed that this advice had been followed.

People told us that they were satisfied with the meals provided at the home. People told us, "We get plenty to eat and we get a choice" and "We get plenty to eat but there's no choice at tea-time." However, at tea-time we observed that people were offered a variety of choices.

We did not see a menu board displaying the day's menu. The registered provider told us they had purchased a white board and were just waiting for it to be fixed to the wall. We observed the serving of lunch in the dining room. Tables were set with tablemats and cutlery and people were offered clothes protectors. The meal looked hot and appetising and people were offered a choice of drinks and desserts following the main meal. Most people were able to eat independently and a small number of people were assisted by a member of staff.

No drinks were visible around the home; people had to wait for staff to serve drinks mid-morning and mid-afternoon. We discussed this with the registered provider, who told us that they would ensure drinks were available for people to help themselves to. They said that this had been the case, but staff had allowed this to lapse.

The registered provider told us that they followed the NICE guidelines 'Supporting people to live well with dementia' and 'Nothing ventured, nothing gained'. We saw that there was signage to assist people to find toilets and that bedroom doors were numbered (and some also had a picture) to help people identify their own bedroom. These prompts helped people who were living with dementia to orientate themselves within the home.

Good

Is the service caring?

Our findings

People told us they were happy living at the home and that they felt staff really cared about them. Their comments included, "Oh yes, I'm sure they do" and "The staff are looking after me perfectly." A relative told us, "I'm happy with the care my mum gets." Staff told us they felt staff who worked at the home genuinely cared about the people who lived there. Comments included, "Staff here definitely care. It's a smaller home so it's homely" and "The staff in the home where my grandma lived were not very good. I decided to become a carer. Staff at this home genuinely care."

We saw positive interactions throughout the day between people who lived at the home and staff. We saw that people were comfortable in the presence of staff, and that staff were kind, attentive and patient. It was clear that people were treated as individuals and that staff knew people's personality traits and likes / dislikes. We saw that people were dressed and groomed in their chosen style, and that women wore jewellery and makeup if this was their choice.

Care plans recorded people's preferred name and we saw that these were used by staff. We saw that staff respected privacy by knocking on doors and asking if they could enter the room. Staff described to us how they protected people's modesty by covering them appropriately during assistance with personal care. One person who lived at the home told us, "Oh yes, it's private. I never feel embarrassed." One person's care plans recorded that they liked to have their hair done every week and coloured every six weeks, and that it was important for them that their clothes matched and that they wore jewellery. We saw that all of these requests were being followed.

Staff told us they promoted people's independence and this was supported by relatives who we spoke with. People's bedrooms were personalised with photographs and ornaments from their previous home, to help them feel 'at home'. One person had their own telephone so they were able to keep in touch with family and friends independently. People told us that staff shared information with them appropriately. One person said, "We always know what is going on." Relatives who we spoke with confirmed they felt there was good communication between themselves and staff at the home.

Information about advocacy was available for people who lived at the home and their relatives. Advocacy seeks to ensure that people, particularly those who are most vulnerable in society, are able to have their voice heard on issues that are important to them. Two people were supported by an Independent Mental Capacity Advocate (IMCA). IMCAs provide support for people who lack the capacity to make their own decisions and have no-one else to represent them.

The need to ensure confidentiality of information was included in the staff induction training programme. We saw that information about people who lived at the home and staff, both paper and electronic, was stored securely.

People's wishes for care at the end of their life were recorded in their care plans, when they had been able or willing to share this information with staff. This showed that people had been consulted about their wishes

for their end of life care.

Good

Is the service responsive?

Our findings

The care records we saw included pre-admission assessments, risk assessments, a care plan and a care plan summary. Topics covered in care plans included general health, medication, personal care, night care, mobility, eating and drinking / nutrition, leisure / occupation / religious needs, emotional care, safety including the risk of falls and communication.

We saw that care plans recorded information in a document called 'Important things to know about me' although we saw some only contained brief information. This included their preferred name, their interests, their care needs and their mobility. A new document called 'My life story' had been introduced to care plans and staff had started to complete this information. One person's care plan recorded, 'Please don't serve me with luke warm, weak tea' and we saw they were served with a cup of hot, strong tea.

We asked staff how they got to know about people's individual needs. One member of staff said, "We talk to them and ask them about their routines and their likes and dislikes. We would consult their family. As we find out more information we would add it to their care plan." We saw that care plans were reviewed each month and updated as required. This meant that staff had up to date information available to them to ensure people's current care needs were met. People had signed their care plans when they had the capacity to do so.

We used the Short Observational Framework for Inspection (SOFI) to observe the care and support provided to some of the people who live at Oak Tree House and to help us understand their experience of living at the home. We found that staff were attentive and responsive to people's needs. We observed that staff made efforts to engage people in conversation.

The 'daily records' folder included daily records for each person who lived at the home, plus a record of any falls, any concerns about pressure area care and body maps. Although there was no evidence that people had not received appropriate food and fluids, and that staff were not assisting people to have positional changes when needed, we noted that some recording in these charts had not been completed consistently. There was no record of the amount of fluid a person should be receiving, not all fluids were recorded in millilitres and fluids had not been totalled at the end of each day. This meant there was no accurate record of the person's food and fluid intake. The registered provider assured us that this would be addressed with staff immediately, and we observed these discussions with staff on the day of the inspection.

Staff told us they had handover meetings at the beginning of each shift and the records we saw on the day of the inspection confirmed this. The home's diary was also read out at each handover meeting so that staff were aware of any appointments or events that had occurred on the day. Each person who lived at the home was discussed so that staff on the new shift were aware of everyone's well-being. Staff said these meetings helped them to keep up to date with people's care needs.

People told us their relatives were made welcome at the home and they could visit anytime. Comments included, "Staff make people feel welcome" and "The home feels comfortable and friendly." Staff told us

that they supported people to keep in touch with family, friends and the local community. Comments included, "We have good relationships with relatives. We know them well. They pop in whenever they like." We noted that the home had 'protected' mealtimes. This is when visitors are asked not to turn up at the home over mealtimes so that people can concentrate on eating their meal with minimum distraction. We noted this was respected by relatives.

Staff were responsible for organising activities at the home. We saw the activity programme but noted it was not followed on the day of the inspection. Staff told us, "People don't always want to do activities but staff do try to encourage them" and "We usually do activities in the afternoons. More people take part in the Summer as they like spending time in the garden." We saw that some people spent time in the garden on the day of our inspection, and that this resulted in lots of chatter about the garden and the local area. However, people who lived at the home told us they would like more to do. One person said, "It gets a bit boring." We fed this back to the registered provider who told us they would ensure suitable activities were available for people.

The complaints policy and procedure was displayed around the home and included in the home's statement of purpose. The complaints log showed that only one complaint had been received during the previous 12 months and that this was being investigated in line with the home's policy and procedure.

People who lived at the home told us that they had not needed to make a complaint, but they would speak to staff if they had a concern or a complaint. One person said, "I would tell them [the staff]" and another said, "We would tell the staff and we would tell each other." Relatives shared this view. One relative said, "All of the staff are friendly. I could speak to any of them if I had a problem."

We saw the outcome of a survey carried out in April 2016. The analysis showed there had been some requests for re-decoration and the quality assurance report recorded that five bedrooms and a lounge had been re-decorated and that some new carpets had been fitted. Other surveys had been carried out during the year to ask people for feedback on meal provision and activities.

Good

Is the service well-led?

Our findings

At the last inspection of the service we were concerned that the quality assurance systems at the home had not identified some of the shortfalls we identified during the inspection and that not all of the documents we asked to see were available. The registered manager told us some of the required information would be forwarded to us after the inspection but some was not sent to us. This was a breach of Regulation 17: Good governance of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we asked for a variety of records and documents during our inspection, including people's care plans and other documents relating to their care and support. Most of these were readily available and others were forwarded to us immediately after the inspection.

The registered provider had produced a quality assurance report, and some quality audits had been completed. The number of falls during the year had been analysed and there was a record of when the falls team had been contacted and any other action taken. The infection control audit had resulted in an action plan which recorded all staff needed to complete training and that the hallway carpet needed to be replaced, both by August 2016. Both of these had been completed. Monthly room audits were carried out that checked on window opening restrictors, cleanliness and any required repairs. The registered provider told us that, if any repairs were required, the information was transferred to the home's maintenance list. We saw the home's medication policy and the monthly medicines audit form, although we did not see any completed medicine audit forms. A care plan audit was due to be introduced. This showed that improvements had been made in the effectiveness of quality audits to monitor that people received safe and appropriate care, and that the home was no longer in breach of this regulation.

The registered provider is required to have a registered manager as a condition of their registration. At the time of this inspection the manager was registered with the Care Quality Commission (CQC), meaning the registered provider was complying with the conditions of their registration. They had only been registered with CQC since 13 March 2017 but had worked at the home prior to their promotion to the manager position. The registered manager was on holiday on the day of this inspection.

We found the registered manager had informed CQC of significant events in a timely way by submitting the required 'notifications'. The submission of notifications allows us to check that the correct action has been taken by the registered persons following accidents or incidents.

We observed that the registered provider interacted with people who lived at the home throughout the day and that these interactions were positive and friendly. It was clear the registered provider knew the people who lived at the home, and people told us they knew who the registered provider and registered manager were. One person told us, "I could speak to either [name of registered provider] or [name of registered manager]."

We asked staff what they felt about the management and leadership at the home and they responded positively. One staff member said, "They are very supportive. You can always go to them for advice" and

another told us, "I could go to either [name of registered provider] or [name of registered manager]. They would provide support if I needed it. [Name of registered manager] is a lovely person and a good manager."

We saw the analysis of a relative survey; seven relatives had responded. Comments were positive, including 'My mother has been very well looked after whilst at Oak Tree House. The staff have been great. She has put on weight and looks a lot better'.

We asked staff to describe the culture of the home. Their comments included, "I like coming to work", "The décor isn't its strongest point but its friendly, homely, welcoming and warm" and "It's home from home with a relaxed atmosphere."

Care staff told confirmed they attended staff meetings and said they could ask questions and make suggestions at these meetings. One person said, "It's a two way process – we discuss things." We saw the minutes of a selection of meetings and these showed that staff were informed about the outcome of the compliance visit by the local authority, health and safety issues and training, and that learning from recent incidents was discussed. Staff were able to contribute to these meetings under 'any other business'. We saw the minutes of both night and day staff meetings held during 2016 / 7.

The registered provider told us that they had learned from 'near-miss' incidents. They described a situation when a member of staff had lost confidence about administering medication when they had almost administered the wrong medicine to someone. They had received additional support and training, but continued to lack confidence. They asked if they could stop administering medicines and the registered provider agreed to this. They said they appreciated the staff member's honesty.

There was a moving and handling champion, and two other staff took the lead in medicines and care plans. This showed that staff were given responsibility for some aspects of care provision.