HC-One Oval Limited

Oakhill House Care Home

Inspection report

Eady Close
Horsham
West Sussex
RH13 5NA

Tel: 01403260801

Date of inspection visit:
11 May 2018
14 May 2018

Date of publication:
05 November 2018

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection took place over two days on 11 and 14 May 2018, the first day was unannounced and the second was announced.

Oakhill House Care home is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. The care home can provide accommodation and nursing care for 49 people in one detached building that is adapted for the current use. The home provides support for people living with a range of healthcare, mobility and sensory needs, including people living with dementia. There were 32 people living at the home at the time of our inspection.

The service had a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered managers, 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.

This was the first inspection of Oakhill House Care Home since HC-One Oval Limited became the provider of the service and registered it with the Care Quality Commission in December 2017. At this inspection we identified areas that required improvement, including breaches of regulation in relation to ensuring staffing levels, safe care and treatment arrangements, quality assurance and governance systems were sufficient to enable staff to meet people's preferences and care needs.

We were told that staffing levels had been assessed based on people's care and support needs and that the service was working towards establishing more consistency in relation to the use of agency staff and recruiting. However, people, relatives and staff felt that there were times when there were insufficient staff or inefficiently deployed staff to ensure people's preferences and care needs were met. One relative told us, "I have no experience of any other home to compare this to but they have a lot of people who need a lot of care. There are times when I come and it's clear my relative needs changing but they have been left sitting there for a while because it's either not time for the toileting round or not their turn. They get distressed then. I think the staff do their best but there's not enough of them." Our own observations in relation to people's mealtimes, access to activities and communal spaces supported this.

People had not always been provided with suitable arrangements for their end of life care to ensure they could experience a respectful, comfortable, pain free, end of life. The provider had learnt lessons in relation to one person's experiences and had refreshed staff awareness and training but people's end of life preferences had not been fully embedded in their care planning. The provider was reviewing its pre-admissions processes to ensure that suitable assessments of need were in place and that relatives were fully consulted where they had the right to be.

Quality assurance systems were in place and being embedded. The provider had used these proactively since March 2018 to monitor the overall quality of the home and to identify any shortfalls and improvements necessary. However, during the four months before this date and as the systems were embedding the provider had not fully ensured that people were protected from the risk of harm or that risks were managed safely. People's dignity and right to have their preferences met in relation to end of life care, eating and activities were also not consistently respected. People's access to sufficient staffing levels and the consistency of their personal care need being met were not always ensured.

People were not always protected from the potential risk of abuse. Staff could demonstrate a good understanding of their safeguarding responsibilities and were confident that if they raised concerns they would be treated seriously. However, in relation to two complaints made by relatives involving people's wellbeing the registered manager did not effectively identify that abuse may have occurred. A social care professional fedback that the area quality director had demonstrated a good understanding of safeguarding and was keen to work to improve the home. However, they also fedback that the registered manager had not always demonstrated a full appreciation of risk in relation to safeguarding.

Staff and the registered manager told us that they had not had much support or contact with the new provider until the area quality director and area director were recruited to. They described that the culture of the service was of a home in transition.

Communication at the home was not consistently effective. Staff and relatives told us that communication with the new provider had been poor after they had initially taken the service over in December 2018. Relatives and staff told us this had improved at the home since the area director was in post in March 2018. The registered manager had addressed and investigated relative's complaints since January 2018. However, relatives told us and discussed in their complaints that the registered manager had not always communicated in a timely way in relation to their concerns and had not always been accessible when they visited.

People's right to privacy and dignity was not always respected when they were in their bedroom. However, we did observe some areas of good practice in relation people receiving care and staff demonstrated a good understanding of how to maintain people's privacy and dignity.

The provider had arrangements in place for the safe ordering, administration, storage and disposal of medicines. People were supported to have their medicine safely when they needed it. Medicines were consistently administered safely and audits identified where improvements could be made. Staff gave medicines respectfully having gained consent.

The registered manager completed risk assessments and a programme of regular health and safety checks to ensure quality was measured and maintained. We observed audit activity for areas including, medicines, and fire safety and infection control. Staff recruitment processes continued to ensure that new staff were safe to work with people

The building was being refurbished and decorated to make it more dementia friendly. The homes dementia champion was actively promoting improved dementia awareness through training staff and introducing the use of memory boxes. Memory boxes can be added to by the person and families and staff told us these memories can stimulate the person, prompting conversation linked to people's life time experiences.

Information for people and their relatives was provided in an accessible format to meet their needs including their cultural presentations. For example, one person was bilingual, however was beginning to

revert at times to their first language due to their dementia

Staff we spoke with understood the requirements of the MCA and people had access to advocacy services to promote their choice and rights in line with legislation. People were supported in line with the principles of the Mental Capacity Act (MCA) 2005.

Staff demonstrated a good knowledge of people's individual needs, backgrounds, preferences and likes and dislikes and had a genuine regard for their wellbeing. People were comfortable spending time with staff who spoke with them in a patient and caring manner.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe

Staffing levels were determined through a dependency tool that assessed people's care and support needs. However, despite the dependency tool being used this did not ensure that staff were deployed suitably to ensure that care and support needs and preferences were met in a timely way. People's needs in relation to skin integrity and continence care were not always managed safely.

People had not always been protected from risk of abuse as the service were not always effective in identifying when an incident or concern should be raised with the safeguarding body.

People's medicines were managed and administered safely and consent gained and respected.

Is the service effective?

Requires Improvement

The service was not always effective

People were supported to maintain their nutrition and hydration needs, and to access advice from healthcare professionals when their health conditions required this. However, improvements were needed to ensure people received their meals in a timely way.

People could not always have free access to all the communal areas in their home.

People were asked for their consent before being supported and the service worked towards the principles of the Mental Capacity Act.

Is the service caring?

Requires Improvement

The service was not always caring

People's dignity and wishes in relation to privacy were not always respected.

Staff demonstrated a good knowledge of people's individual needs, backgrounds, preferences and likes and dislikes. People were supported to maintain their individual identity.

People were cared for by kind staff. Their differences and diversity were respected and staff would adjust their approach to meet their needs

Is the service responsive?

Requires Improvement

The service was not always responsive

Care plans were on the whole accurate and personalised. However, pre- admission assessments and end of life care planning had not always ensured people received suitable care and treatment.

Activities were planned for and the activities worker had a good knowledge of people's interests and preferences. However, meaningful activities were limited due staffing levels.

People's backgrounds and life histories were evident within their personal spaces and care plans and staff had a good knowledge of people's life experiences.

Is the service well-led?

Inadequate

The service was not always well-led.

Quality assurance systems were in place and being embedded to monitor the overall quality of the home. However, they had not robustly identified areas that required improvement.

Relatives and staff gave mixed feedback in relation to the service being well-led. Communication between the new provider and relatives had been delayed which was concerning for relatives. Feedback indicated issues in relation to staff morale, support from the provider and concerns about staffing.

The registered manager, area director and staff described that the service culture was in transition.

Oakhill House Care Home

Detailed findings

Background to this inspection

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

This inspection took place over two days on 11 and 14 May 2018, the first day was unannounced. The inspection team consisted of two 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. The expert-by-experience for this inspection was an expert in care for older people with dementia.

Before the inspection we reviewed the information that we held about the service and the service provider. This included statutory notifications sent to us by the registered manager about incidents and events that had occurred at the service. A notification is information about important events which the service is required to send to us by law. The inspection was prompted in part by notifications detailing concerns of an incident that put a person using the service at risk. The information shared with CQC about the incident indicated potential concerns about the management of risk in relation to pre-admissions assessment and end of life care.

We contacted stakeholders, including the local authority contracts team and health and social care professionals involved in the service for their feedback two professionals gave feedback regarding the service. We looked at concerns we had received from people who had contacted the CQC in relation to personal care and staffing levels. We used all this information to decide which areas to focus on during our inspection. On this occasion we had not asked the provider to complete a Provider Information Return (PIR) at the point of 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.

During the inspection we observed the support that people received in the communal areas. We were also invited in to people's individual rooms. We spoke to six people, six relatives, seven staff, the registered manager and the area director and area quality director. We spent time throughout the day observing how people were cared for and their interactions with staff and visitors to understand their experience.

We reviewed five staff files, medication records, staff rotas, policies and procedures, health and safety files, compliments and complaints recording, incident and accident records, meeting minutes, training records and surveys undertaken by the service. We also looked at the menus and activity plans. We looked at people's individual records, these included care plans, risk assessments and daily notes. We pathway tracked some of these individual records to check that care planned was consistent with care delivered.

This was the first inspection of Oakhill House Care Home since HC-One Oval Limited became the provider of the service and registered it with the Care Quality Commission in December 2017.

Requires Improvement

Is the service safe?

Our findings

Before this inspection, we had received information that there were not always sufficient staffing levels and that people's personal care was not always provided in a way that met their needs. On the inspection, people, relatives and staff told us there were not always enough staff on duty to support people at the times they wanted or needed to be supported. One person told us, "I feel safe here but it's not the same as it used to be, it's gone downhill." A relative told us, "I think my relative is safe. Whenever I've seen them the staff always treat them with respect. There often doesn't seem to be enough staff on duty but that may be because most people need two staff."

The registered manager told us that staffing levels were based on a dependency tool that calculated the number of people and their care needs to calculate how many staff were required. They confirmed that two registered nurses should be available each shift, however this had not been the case for some time and rotas from March 2018 evidenced this. There was a heavy reliance on agency staff and the registered manager told us the support required to introduce new staff regularly affected the skills mix required for the service to run smoothly.

We looked at staffing and staff deployment at the home, and asked people and their relatives whether they felt there were sufficient staff on duty to meet their needs. We received mixed feedback. A relative told us, "A lot of really excellent staff have left since the takeover and there are lots more agency staff." One person was recorded in the recent resident's forum minutes, "Carers are very good but there are not enough of them." Staff told us that at busy times of the day, for example when people needed two staff to support them get up they could be stretched. Staff also commented on the number of agency staff in the home, and how at times due to short notice sickness or changes in staffing there could only be five staff supporting people. One staff member told us, "When you have five carers it becomes difficult, you have to be primarily on the floor keeping people safe, you can't do paperwork. The dependency tool is limited, it doesn't take into full account the support the more able people need to be encouraged to eat and be independent." Another staff member told us, "I haven't see seen staff having a joke and a dance with people for some time. It's not nice seeing people waiting for assistance. Our own observations supported the feedback we received.

On the first day of our inspection, we observed that most people were still being supported with their personal care and breakfast in their rooms at 11am. Eight people, three of whom required support with eating and drinking were supported by one staff member in the main dining area one person had to wait 40 minutes before they were supported to eat. We asked the staff member how they met the needs of the people present. They told us it was stressful to balance the needs of the people who required encouragement and assistance with eating with those who were more independent. When supported to leave their bedrooms people spent their time in the main lounge area, and other communal spaces were not accessed. On the first day of the inspection the registered manager, a senior manager and the staff on duty were supporting people with their lunch time meals and three relatives were supporting their loved ones. We observed that on this occasion with additional help the lunch time took two hours to complete, which demonstrated that with fewer staff, managers and relatives available it would be difficult to meet people's nutritional needs in a timely way and that people's opportunity to access other activities would

consistently be reduced. Before and during the inspection we received feedback from relatives that confirmed people were often supported in the lounge, for lengthy periods of time by one staff member. On the second day of the inspection people were supported to use other areas of the building and one person went out of the home with the support of a staff member, however there were ten staff onsite due to one staff member being inducted.

We discussed staffing levels with the registered manager and with the area director and were made aware that the registered manager had recently resigned. We were told that the staffing levels were constantly under review and that they felt the dependency tool provided sufficient staffing levels. The area director told us that staff were not always suitably deployed and they were actively recruiting for a new clinical lead, a registered manager, four registered nursing roles, a number of care staff and another activities worker. In addition, they had requested that a registered manager from another home support the recruitment of permanent staff and develop a more consistent pool of agency workers to ensure there was more consistency of care.

The above evidence demonstrated that there were not always sufficient numbers of staff suitably deployed to ensure people's support and care needs were met promptly or safely. This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities).
We observed some areas of good practice in relation to how the service managed risk. People had risk assessments in place that considered the potential hazards, risks and control measures for several areas of their life. These included falls risk, moving and handling, food and nutrition, communication, skin integrity, continence and medicines including the use of covert medicine.

However, in relation to where people required regular support with personal care or were at risk of pressure damage. Although care plans and records were detailed and gave staff guidance on how the risks should be managed safely including skin integrity risk assessments, pad change monitoring and repositioning schedules. Staff and relatives fedback concerns about the timeliness of personal care. One relative told us, "I have no experience of any other home to compare this to but they have a lot of people who need a lot of care. There are times when I come and it's clear my relative needs changing but they have been left sitting there for a while because it's either not time for the toileting round or not their turn. They get distressed then. I think the staff do their best but there's not enough of them." We found shortfalls in the documentation used to record this. For example, on the second day of the inspection we found gaps in three people's daily records from the three previous days making it difficult to establish whether they were being adequately supported with their continence care.

After the inspection we received feedback from the home's GP that in relation to people living at the home there had been a large number of cases of skin irritations and in some people, had been recurrent. They confirmed that this was going to happen at times when people were less mobile and not able to complete their own personal care. However, there were instances of problems relating to pressure area care that had not resulted in longer term harm that a senior health professional had felt could have been prevented by standard good nursing care.

The above evidence demonstrated that there was a shortfall in the overall effectiveness of the systems to assess, record and mitigate risk to ensure people's continence and skin integrity needs were managed safely. This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities).

People were not always protected from the potential risk of abuse. Staff understood people's needs and the types of abuse people living with dementia experienced. Staff received training and guidance on how to recognise and report abuse and were confident that if they raised a concern with their manager it would be

taken seriously and acted on. The registered manager had previously raised safeguarding incidents and been involved in completing safeguarding enquiries with the local authority in relation to a complaint about end of life care and an incident relating to staff conduct. However, in relation to these enquiries we received mixed feedback about how the safeguarding incidents were managed. A social care professional involved in the enquiry fedback, "Despite conversations with the registered manager regarding risk, there seemed to be little understanding of the urgency of the issue and the need to change 'end of life care' procedures. These changes were facilitated by the area quality director who seemed to have a good understanding of the safeguarding concerns and was keen to work with social services to improve the home."

During the inspection we noted two complaints from February 2018 from relatives concerned about the staffing levels, nutritional support, medicines and poor personal care. The registered manager investigated these allegations as complaints but did not identify them as potential safeguarding concerns or alerted the appropriate bodies in line with the local authority safeguarding. The registered manager failed to report the incidents to the local authority, so that they could be fully considered and investigated. We shared our concerns with the registered manager and the area director that the complaints described could meet the threshold for safeguarding enquiries to be alerted. They completed safeguarding alerts in relation to the two concerns on the same day. This is an area of practice that needs to improve.

People were protected from the risk of harm as risks to safety and incidents were identified and effectively managed. Staff completed incident reports following accidents. Accident and incident records dated March 2018 to May 2018 detailed there had been seven incidents including five falls. Where people had experienced falls, the risks were reviewed using a falls risk assessment and falls diary and guidance given such as supervision levels required and managing the environment including the use of sensor mats and hourly checks defined. Personal emergency evacuation plans (PEEPs) were in place to ensure people's individual ability to evacuate the building in the event of an emergency was considered and planned for.

People were protected by the prevention of infection control. The provider had introduced more frequent cleaning schedules and staff attended regular training in this area and PPE (personal protective equipment) was used and available when required including aprons and gloves.

We looked at the management of medicines and observed they were consistently given safely and that audits completed identified where improvements could be made. Staff gave medicines respectfully having gained consent. We observed controlled drugs medicines and time critical medicines being given suitably and in line with the medicines policies and systems. Staff told us they had clear guidance on how to safely store, audit, record, administer and dispose of medicines. For example, one person who was in receipt of covert medicines had their medicines regularly reviewed in line with their GP information, care plan and capacity assessment. Senior care staff and nurses including agency nurses that administered medicines were trained and assessed as competent to do so. The medicines administration records were complete without gaps which demonstrated that people were receiving their medicines as they were prescribed.

Environmental risk assessments, audits, team meetings and a programme of regular health and safety checks demonstrated that measures were in place identify potential risks and reduce the potential for harm. The provider had oversight of health and safety through audits and checks of accidents and incidents, fire safety, risk assessments, COSHH, LOLER and Legionella checks and emergency plans. The maintenance person told us that in addition to the regular audits and checks, they also completed daily checks to ensure that call bells were responded to in a timely manner and monitored that air mattresses were set at the correct setting for the people using them.

Staff recruitment processes ensured that new staff were safe to work with people. Staff files included

previous work history, application forms, proof of identity and suitable references. Records demonstrated that checks had been made with the Disclosure and Barring Service (DBS) to ensure staff were suitable to work with people. Documentation confirmed that nurses employed had up to date registration with the nursing midwifery council (NMC).

Staff received training in equalities and diversity awareness to ensure they understood the importance of protecting people from all types of discrimination. The Provider had an equalities statement prominently displayed in the entrance of the home, which recognised their commitment as an employer and provider of services to promote the human rights and inclusion of people and staff who may have experienced discrimination due to their ethnicity, religion, sexual orientation, gender identity or age.

Requires Improvement

Is the service effective?

Our findings

People's preferences, choices and care needs were not always met. People and relatives gave mixed feedback in relation to how well staff knew people and whether the care given effectively met the needs of people living with dementia with additional health needs. One person told us, "If I'm not well they tell the doctor. I like some of the staff and they are very helpful, but there's such a lot of us to look after." One relative told us, "They have lost a number of excellent staff since the new provider took over, but the regular staff that are left are very good. I have seen them asking people if they can help them." Another relative told us, "I'm not sure how well trained in looking after people with dementia they are, but they are always pleasant to me when I visit. We have concerns whether my relative eats and drinks enough but we can't be there all the time, you just have to trust them to look after them. Another relative told us, "The carers they have retained are ok, not especially well trained in caring for people with dementia. I don't think they have enough staff to do more than the basics."

We observed three mealtimes during the inspection, one breakfast time and two lunch times. People were supported to move to the dining area, or could choose to eat in their room or the lounge area. The chef told us, "It doesn't matter what people see as meal times, this is their dining room and we fit in with them." People who could eat independently were encouraged to be independent throughout the meal and staff were available at the kitchen serving area if people wanted extra food or additional choices. People's food preferences and dietary needs were discussed with them and their relatives on their admission to the home. Menus were reviewed and adjusted as people's needs changed including the introduction of soft food diets for people with swallowing issues. However, although some people had a choice of where and when they ate we found areas of practice that needed to improve.

On the first day there was one staff member available in the main dining and lounge area to assist people with their breakfast. There were three people who required direct support with eating, and five people who could eat independently. While one person was supported with eating, two people were left with their breakfast in front of them for 40 minutes without being encouraged or supported to eat. One of these people's care plan included eating and swallowing guidance that detailed they needed to 'take extra' time when eating and drinking and should be 'encouraged to self-feed' when possible. The records of the two people we observed waiting for support to eat demonstrated that they had maintained their weight recently. However, in light of staff not being available to support them in a timely way during this mealtime, their preferences and needs to be supported and encouraged to eat were not met and we have identified this as an area of practice that needed to improve.

Due to their health conditions, many people were at risk of malnutrition and dehydration. Staff understood the importance of monitoring people's food and drink intake and monitoring their wellbeing. For example, one staff member told us that towards the end of March 2018 many people had lost weight after a flu outbreak at the home, and records including staff meetings confirmed this. Where people had been identified at risk of weight loss this had been identified on the clinical risk audit, their care plans and food and fluid charts were in place which enabled staff to monitor people's nutrition. People's weights were recorded monthly, and where people had lost weight staff had discussed the importance of accurate record

keeping and sought advice from the GP and made referrals to the Speech and Language Therapists and dieticians to promote their wellbeing.

The building was being refurbished and decorated to ensure it was safe, dementia friendly and well maintained. The provider was not using the upper floor of the building during the inspection as they had taken a decision to close the floor for refurbishment. Consent was gained from people, their relatives and the local authority to move two people downstairs while the changes took place. The provider had a newly appointed director of memory care who was supporting the refurbishment plans to ensure it was more person centred and focussed around memory care. The maintenance worker had also visited another home within the organisation to explore how they used colour to support a more dementia friendly environment. They told us they were going to use more colours and themes to define different areas. The home had a dementia champion' and had made some changes to the home environment using nostalgia based references in corridors for example, pictures of film stars, textured wall features and framed newspaper event, for example, the assassination of John F Kennedy. People's bedroom doors had a picture of them to support their orientation.

The environment was spacious and with suitable staffing arrangements would enable people to move around freely without risk of harm. The home had a large sitting room, dining room, sun lounge, library and a well-equipped and spacious activities area. Bathrooms were accessible and equipped for people with limited mobility. Some bedrooms had ensuite facilities. The grounds were well maintained with a self-contained courtyard so that all people could access the outside space safely. On the first day of the inspection we did not observe any of these areas being accessed by people. One staff member told us, "We've made progress making rooms and corridors more homely. But we should be making more of the communal rooms; we have a garden room, library, upstairs lounge, but it's not feasible to use them with staffing as it is. On the second day of the inspection we observed people using the activities area, sun lounge and outside courtyard. We noted that there were ten staff available due to one staff member being observed as part of their induction. This demonstrated that people were not consistently free to use other areas of their home and is an area of practice that needed to improve

Staff including the cook, maintenance person and agency staff told us they felt well supported and equipped to carry out their roles. Staff received training and inductions that included, shadowing experienced staff who could demonstrate how to work with people with complex needs. For example, one staff member told us they received intensive training where they learned how to use stand aids, hoists and how to support people with contracted limbs. Staff also had access to training that was specific to the needs of the people using the service, including dementia, infection control, moving and handling, MCA (Mental Capacity Act) and person-centred care. For example, the dementia champion told us the provider had given them time to provide their colleagues with training, "I relate training to our experiences in the home and try to respond to issues as they arise." Staff told us that they found this helpful and felt well supported by colleagues and regular team meetings that took place. Staff had access to the Skills for Care certificate. The Skills for Care certificate is a set of standards for health and social care professionals that ensures that workers have the safe introductory skills, knowledge and behaviours to provide compassionate, safe, high quality care and support. Formal supervision sessions took place although staff gave mixed feedback on the frequency and appraisals had been identified as an area that the service needed to improve on through its own quality assurance systems. This is as an area of practice that needed to improve.

People who lacked mental capacity to make decisions were protected. Staff demonstrated they understood and were working in line with the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS). The Mental Capacity Act 2005 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 capacity to make 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 interest and legally authorised under the MCA. Staff had a good understanding of the MCA and the importance of enabling people to make decisions and received training in this area. Where decisions were needed in relation to complex matters including; finance and medical interventions, mental capacity assessments and best interest assessments took place and their decisions recorded.

Staff encouraged choice and recognised that the needs and capacity of people living with dementia could fluctuate or be limited to a few days to day choices. One staff member told us, "We recognise what people can do for themselves and offer choices of clothes and meals and where they want to sit or eat." To ensure people could be offered choice in an accessible and meaningful way staff used a range of communication methods including showing them clothes and food options. Where one person did not have a family, member involved in supporting their decision making about their room being redecorated an advocate was provided to ensure the person's choices were respected. People were also encouraged to use technology to communicate with their families; including skype via phones. The activity worker told us of one person that they supported once a week to do this. The area director told us that the building would be having wifi available as part of the refurbishment changes.

CQC is required by law to monitor the operation of the Deprivation of Liberty Standards (DoLS). DoLS are the process to follow if a person has to be deprived of their liberty in order for them to receive the care and treatment they need. Individual bedrail assessments gave clear information about the potential risks the use of bed rails managed and how people could be supported in the least restrictive way. For example, one person found being handled uncomfortable due to their condition, care plans gave guidance and staff told us how they would respect the person choice if they refused support to move. Strategies were in place for staff that included one staff leading the support and providing reassurance by explaining what they were doing and holding the persons hand. Health professional's notes detailed that this approach had resulted in no incidents of the person presenting a risk to others in recent months and had minimised the person distress.

We noted that some care plans in the new providers format did not have the mental capacity assessment documents available, however they were still available and completed in the previous providers format. The registered manager was able to access the relevant assessments and confirmed they would be transferred to the new documentation. The registered manager told us that they were aware of when and how to make an application for a DoLS authorisation and had oversight of current applications, and their progress from local authorities.

Requires Improvement

Is the service caring?

Our findings

In the main positive, kind and caring relationships had been developed between people and staff. People and relatives told us staff were kind and caring. One person gestured towards a staff member and told us, "Yes they're quite kind. That little girl there comes and reads me a story sometimes, I like that." Another person told us, "The staff are lovely, they would do anything for you, they look after me really well. We asked relatives whether they thought staff were caring. One relative told us, "Yes I think the staff are kind, they are certainly kind to me and my wife." Another relative told us "I've never noticed them being especially kind, I think the regular staff are fairly good. You never notice anyone seeming frightened of them." However, during the inspection we observed that people were not always free to move around the home, due to staff availability, and some had their dignity and privacy compromised.

In relation to dignity and privacy being promoted we saw some areas of good practice. For example, staff supporting people with personal care or medicines requiring them to return to their room for privacy, were considerate and discreet in how they explained this to people before supporting them to go to their room. Staff spoke respectfully about people's needs and where bedroom doors were closed, knocked on them and gained consent before entering people's rooms. However, although staff could describe how they maintained people's dignity and privacy, we found that the principles of privacy and dignity were not consistently embedded. For example, on the first day of the inspection there was an incident where one person's privacy and dignity was not respected. The person's care plan stated, "I am a private person, I prefer staying in my room and watching TV." We observed the person lying on their bed, back facing the open door and their buttocks and continence pad were clearly visible to any person passing the door. We brought this concern to the attention of the registered manager explaining that the door had been ajar for at least 15 minutes and they acknowledged that the door should not have been left open and closed the door. This demonstrated that staff did not always ensure the person's dignity and wishes had been respected. This is an area of practice that needs to improve.

In relation to people's independence and wellbeing, we saw some areas of good practice. Staff were genuine in their concern for people's wellbeing and right to independence. For example, one person would forget they had eaten their breakfast and staff would reassure them that they had and described what they had eaten to support them to reduce their anxiety and then use a distraction technique by offering a drink. Another staff member was observed comforting a resident who was crying, firstly by trying to establish what was upsetting them and then by giving them a hug for reassurance. We observed one person being given the time to feed themselves independently in their chair, as they were very clear with staff that they wanted to do this independently even though their condition meant that it took them longer to do so.

However, although we noted some areas of good practice at times that staff were available in the communal spaces, people were not always supported to maintain their independence and rights to be able to move freely around the building. During the morning of the first days' inspection several staff members were not available to people as they were supporting people in their bedrooms with personal care. One staff member was available to support people in the main lounge and dining area at this time. Relatives also feedback to us that the activities coordinator was regularly the only person in the lounge and responsible for the needs

of large groups of people, which they were concerned about. This demonstrated that people could not use the other communal spaces in the home; including the quiet lounge, sun room and garden area freely if they wanted to. We observed one person who was at risk of falls and required constant monitoring trying to leave the lounge, and they were encouraged back into the lounge by the staff member present to ensure their safety. This demonstrated that they were not always able to freely move around the building and access the communal spaces and is an area that needs to improve.

Relatives were involved in the review and planning of their relative's care, when they had the legal authorisation to do so. They told us they could visit whenever they wanted to and were always welcomed and informed of any issues relating to the health and wellbeing of their loved one. The dementia champion, told us, "Good dementia practice means giving people a voice and learning as much about them as possible, we include relatives in that too."

People were comfortable in the company of staff. Staff were genuine and warm in their conversations and gave good eye contact and adjusted their height when speaking to people using appropriate touch to reassure and encourage them when they were upset. We observed staff approaching people in a patient and gentle way and comforting people who became distressed.

Staff, the cook, the maintenance person and nurses demonstrated a good knowledge of people's individual needs, backgrounds, preferences and likes and dislikes. For example, one staff member told us one person we support loves music and dancing, "When I have time, I ask them, shall we dance? Their face lights up when they dance." Another staff member of the team demonstrated a good knowledge of one person's background, their previous career, and how their lifestyle had impacted on their relationships, health and mental health. The staff member told us, I make time to chat with people, some people don't have many visitors and it's important to have regular chats so they feel less isolated."

People's differences were respected and promoted within their day to day lives and care planning. People were able to maintain their identity; they wore clothes of their choice and their bedrooms included personal possessions, furnishings and photographs, for example one person was keen on crafts and had a knitted patchwork blanket and tapestry in their room. Differences were respected in relation to people's religious expression and national identity and care plans, and dietary guidance demonstrated this. For example, one person's bedroom door reflected their name written in the alphabet of their first language. One staff member told us that diversity was a natural part of person centred care, "We all live in a community, we all have gay friends and relatives we have professional training about respect and diversity." Staff were aware that the person's dementia at times meant they reverted to their first language, but that they still understood and used English. Another person's choice to maintain a vegetarian diet was respected and the cook told us that they had worked with the person's family to expand the number of dishes the person ate, introducing more options including vegetable pies and risotto's.

People had access to relevant advocacy services so that they could be actively involved when making decisions about their care.

Requires Improvement

Is the service responsive?

Our findings

People were not always supported with personalised care that continued to respond to their needs. Communication with relatives and health professionals was did not always ensure people's end of life care needs were met or that relatives were communicated with in a timely way. Staffing was not always sufficient to consistently provide people with choice in relation to activities and. Some people were involved where they could be in making decisions about their care and support needs. One person told us, "They always treat me right, they're good girls." Relatives told us they visited regularly and were free to visit at any time and were always made to feel welcome.

We observed some areas of good practice where people and their relatives were involved in the initial planning and assessment of their social, physical and health needs. For example, people's preferences and choices were identified and included within their care plans. One person's care plan detailed, that at night they liked a light left on and how they liked their pillows adjusted. However, relatives gave mixed feedback on how the home involved and communicated with them in relation to their relative's care. One relative told us, "The staff are very good at keeping me informed about changes in how things are. They consult me over things because I hold the Legal Power of Attorney, for my relative, and I'm here every day. I have never complained but I am concerned about the shortage of staff." Another relative told us, I can't remember being involved in a formal review but they do notify me if there's any problems with my relative, otherwise they don't tell you unless you ask. The provider took over six months ago and communication and staffing levels are an issue I think."

When needed the staff provided end of life care for people. However, people's care plans did not always describe their preferences including if they wanted to remain in the home or go to a hospice or hospital. People's religious and cultural needs were not always explored in relation to advance care planning and the home was still embedding lessons learnt from a recent safeguarding enquiry carried out after a relative's complaint in relation to end of life care at the home. Staff told us they continued to look to improve how they supported people so that they could experience a respectful, comfortable, pain free, end of life. The provider had investigated the complaint and contributed to a safeguarding enquiry. In response to the complaint findings and safeguarding the provider had carried out actions including; refreshed staff training in end of life care and reviewed its pre-admission assessment documentation and how relatives were involved and engaged with in the planning of end of life care at short notice, as this had contributed to the complaints concerns.

Pre-admission assessments were being completed for people admitted to the home. However, they did not always ensure the service could meet their needs. For example, the person who's end of life care led to a relative's complaint became ill after the initial assessment was carried out and was discharged without the original pre-admission assessment being reviewed. The relative's expectations in relation to the discharge were different from the homes which resulted in a delay in the person receiving access to pain management. The social care professional who carried out the safeguarding enquiry, told us, "It has become clear that thorough pre- admission assessment had not being conducted following the change of needs. Needs were assessed via hospital over the telephone. However, needs were not accurately reflected over the telephone

and adequate preparation had not been made to manage end of life care." This they felt had reduced the person's dignity within their end of life care. The area director told us the home recognised that better communication with the person's relatives prior to admission would have ensured that their expectations could have been understood, respected and met timelier. The area director also fedback that they would in future be screening all new admissions to ensure the home could meet people's needs, especially people with higher dependency needs. Staff did not always communicate effectively with relatives or respond effectively to people's health and changing needs. This is an area of practice that needed to improve.

A range of meaningful activities were planned for people. However, a lack of staffing meant that they were not always delivered in a way that met people's preferences or care needs. For example, one person's care plan detailed that they enjoyed sitting in the garden watching the birds while they smoked. Due to their mobility needs this was dependent on staff being available to support their access outside, and for long periods on the first day of the inspection this would not have been possible.
An enthusiastic activities worker had access to an activities room, and resources including; DVDs, craft material and books. The activities worker had a good knowledge of people and their needs and abilities. During the inspection a singer entertained people and the activities worker supported people to access some sessions in one area of the lounge; including, storytelling and reminiscence activities. However, the activities worker told us on many occasions they were the only staff member in the lounge which limited what activities they could provide for people on a one to one basis. One staff member told us, "We have dementia awareness as part of our routine training, it reminds us what the job should be all about, but the allocated work doesn't leave space for extra." Further to this due to staff levels they could not always support people to access activities in the community or other parts of the building, such as the library room, sun lounge or activities space. Relatives told us that the activities worker was often the only staff member in the lounge when they visited and that they were responsible for large numbers of people at these times.

Further to this several complaints had been received since January 2018 in relation to personal care, access to activities, the responsiveness of the registered manager and staffing arrangements including the use of agency staff. During the inspection we saw that many people were cared for in bed or required two staff to support them with personal care and moving around the home. One relative shared their concerns in relation to their loved one being supported by unfamiliar staff. They told us, "There's a high turnover of staff and when new ones come they have to show them what to do for people. All that takes time which means there's less time to spend with people. Sometimes people just need someone to sit with them and hold their hand. My relative gets distressed when they are soiled but new staff or agency wouldn't necessarily recognise what is making her upset."

People and relatives were becoming more confident that complaints were taken seriously felt able to raise concerns they had with the registered manager and area director. We looked at the complaints policy and records and saw that complaints were taken seriously, investigated and actions taken to resolve concerns. However, this had not always been in a timely manner as detailed in one relative's complaint letter.

People's backgrounds and life histories were evident within their personal spaces and care plans. Staff told us that care plans and guidelines were clear and that they built on this knowledge through team discussions and contact they had with people and the choices they made. For example, one person had a crochet blanket and embroideries that they had made in their room. In the communal hallways and sitting areas there were nostalgia based references to familiar 1950's celebrities and historical events. The dementia champion had also promoted the use of framed memory boxes by their bedroom doors. Memory boxes can be added to by the person and families and staff told us these memories can stimulate the person, prompting conversation linked to people's life time experiences. For example, one memory box contained handwritten recipe books, garden photos, an Easter motif cross, wool and a scone cutter. This was because

the person had been a keen baker who enjoyed crafts and gardening.

Information for people and their relatives if required could be created in an accessible format to meet their needs and to help them understand the care available to them. For example, there were pictures available showing which staff and nurses were on duty. Staff received guidance and information in relation to people's needs. For example, one person was bilingual, however was beginning to revert at times to their first language due to their dementia. Care plans included detailed information about people's communication needs and specialist health needs, including diabetes and sight loss. The area manager told us that as part of the home's refurbishment they would be making wifi available throughout the home to further improve people's access to technology and provide more opportunities for them to communicate their needs and with their families.

Inadequate

Is the service well-led?

Our findings

People, relatives and staff gave mixed feedback on whether the home was well-led. Relatives spoke about the recent change in provider and that this had left them feeling uncertain about their relative's future. One relative told us, "We'll have to see what happens next." We asked relatives if they felt the home was well led. One relative told us a simple, "No." Another told us, "I'm not here often enough to comment." Another told us, "The staff that are here do their best and work hard but they've lost a lot of very good carers and nurses in the last six months and they are always short of carers. I often visit and don't recognise any of the carers faces, and that's not good for people with dementia, they need continuity." Our own observations supported the feedback we received and we have identified areas of practice in relation to quality assurance that required improvement.

Quality assurance systems were in place and being embedded to monitor the running and overall quality of the home and to identify any shortfalls and improvements necessary. The registered manager completed daily and weekly management reports that informed clinical risk meetings and organisational systems. The area quality director who had been in post since March 2018 carried out monthly visits to inform a 'home improvement plan' which included the oversight of areas including; staff deployment, care plans, medicines risk management and dignity in dining. Any concerns identified in these reports were then escalated to senior managers. However, these systems of quality assurance had not been robustly in place when the provider had taken over the service, or after this ensured that people had received safe, personalised care that met their needs. For example, people were not always protected from the risk of abuse as the registered manager had not identified safeguarding concerns being addressed as complaints and had failed to share these with the appropriate bodies or work in a timely way to ensure they were investigated. People did not always have their continence and skin integrity needs safely managed or risks fully mitigated as staffing and monitoring arrangements were not suitably robust. People's right to dignity was not always maintained in their personal spaces, or their preferences and needs met in relation to their end of life care, eating arrangements and access to meaningful activities.

Further to this the area director told us, "Oakhill is very much a service in transition." This they explained had been a difficult transition as the previous provider had not provided them with full information and records. They confirmed that recent complaints made by family members and information highlighted through quality assurance visits had made the home a priority for the area quality director when they began their role. For example, they highlighted that staffing levels were not correctly assessed or implemented. Staffing levels were informed using a dependency tool, that calculated the staffing levels required. The registered manager and area director told us that there were suitable numbers of staff based on this methodology and that they were working on how staff were allocated. However, feedback from people, their relatives, staff and our own observations showed that staffing levels were not sufficient to ensure people's needs could be met safely, and this was evident throughout the shortfalls identified during the inspection.

This demonstrated that people were placed at risk, as the provider did not have adequate systems and processes in place to enable them to fully assess and identify where safety and personalised care needs and preferences were compromised and to respond without delay. This is a breach of Regulation 17 of the

Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

We asked staff about the culture of the service, one staff member told us, "It's getting better, I have got to know people and I'm not afraid to ask questions." Another told us, "The home has been let down by the previous provider, the managers are being supported now." They told us that they felt that the role of managing the service was too big a job for the registered manager. The staff member described that there were a lot of improvements to make but that it was important to remain positive. The registered manager described that the culture was affected as there was lots hanging in the balance as the home had functioned not as one provider or the other during the transition. In terms of the organisation of the service, the scheduled planning from the previous provider had not been fully replaced, rather changes had happened in 'dribs and drabs.' This was demonstrated on the day as policies were still being introduced by the new provider that were replacing those of the previous one. For example, the duty of candour policy was being replaced, and we noted some care plans in the previous providers format and in the new providers format did not have the mental capacity assessment documents in their format, as they were still available in the previous format. The registered manager could access the relevant assessments and confirmed they would be transferred to the new documentation. This is an area of practice that needed to improve.

The registered manager understood their responsibilities in relation to their registration with the Care Quality Commission (CQC). The registered manager had submitted notifications to us, in a timely way. This meant that we could confirm that the appropriate action had been taken. There was a policy in place in relation to the Duty of candour and the manager was aware of their responsibilities under the Duty of candour. This is where a registered person must act in an open and transparent way in relation to the care and treatment of people.

The registered manager told us that they had experienced a period during the transition from the previous provider to the new provider, where they had felt less supported in their role. For example, they told us that their induction with the new provider had been, "Hit and miss." They had had a corporate day with the new organisation and had been offered e-learning but had not had a 'buddy' or link with the wider organisation to help with the transition and improvements required of the service, until March 2018 three months into the transition. The registered manager told us, "I have felt so stressed, there is so much to do and no real help up until recently." Since the area director and area quality director had become more involved with the service in April 2018 this had improved and they had received more support. However, they told us and the area director confirmed that they had taken the decision to resign from their role and complete their notice period. The area director confirmed that they were visiting the service two days a week and recruiting to a registered manager, a deputy and clinical leads post, and had ensured that an experienced registered manager from another service was supporting the service three days a week, to oversee the day to day management of the home, ensure adequate and consistent agency cover was in place while staff were recruited.

We asked staff and health professionals about how the home was managed. One staff member told us, "The lack of consistency of management hasn't helped the home. We are still in transition. The provider seems to want to listen, they have asked for ideas. Another told us, "Some people were ready to move on and uncertainty about change led them to do so. But we need to see them replaced. The home is on the up, it's a strong staff group and we just need enough staff and stable management." A GP who had visited the home regularly over two years told us that the people living at the home had very complex medical, physical and emotional needs and required a high level of support as did their relatives at times. Due to this the staff working in such a service required high levels of support from efficient management. They told us, "The management has turned over frequently recently and surely had a destabilising effect has, I sense not enabled a strong management structure to be implemented. I have felt at times that the management was

too detached from the clinical staff."

Recent meetings provided people and relatives with an opportunity to feedback about their concerns and quality of the service provided, as surveys had yet not been completed by the new provider. Feedback outcomes consistently referred to staffing turnover. People confirmed that they were happy with the quality of staff support and food. However, they also identified that they would like more activities. Relatives met with the area director and area quality director in April 2018 to discuss their concerns in relation to the future of the home, staffing, the use of agency, people's well-being and access to activities, maintenance concerns and the homes culture. It was acknowledged at the meeting that this was the first meeting with the provider since they took over the service in December 2017. The area director agreed that future meetings would take place to improve the communication with relatives and agreed to set up monthly clinics for relatives to talk directly and openly about their concerns.

A social care professional feedback that in relation to contact they had with the home during a safeguarding they did not feel that the registered manager had a good overview of what was going on in the home. In relation to partnership working with social services they told us that communication had been poor and that important reports were not always forwarded, and at times there was little sense of urgency in relation to risk. The area director had facilitated better communication since they arrived and demonstrated a good understanding of the safeguarding concerns and was keen to work in partnership to improve the service, while being open and transparent that mistakes had been made.

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 12 HSCA RA Regulations 2014 Safe care and treatment 12 (1) (2) (b) The provider had not always ensured the overall effectiveness of their systems to assess, record and mitigate risk in a way that safely met people's continence and skin integrity needs.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing 18 (1) The provider had not always ensured that staff were deployed in such a way that met people's preferences and care and support needs in a timely way.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance 17 (1) (2) (b)(c) The provider had not always ensured that they had quality systems and processes that robustly assessed, monitored and mitigated risks relating to the health and welfare of people using the services.

The enforcement action we took:

Warning Notice issued requiring the provider to be compliant by 20 November 2018.