PWC Care Limited

Oak Tree House Residential Care Home

Inspection report

Oak Tree House, Oak Tree Estate
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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We carried out an unannounced comprehensive inspection of this service on 8 January 2015. Four breaches of legal requirements were found. After the comprehensive inspection, the registered provider wrote to us to say what they would do to meet legal requirements in relation to the breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These breaches were in respect of the administration of medication, the safety and suitablity of the premises, staff training and following published research and guidance.

We carried out a focused inspection on 11 September 2015 to check that the registered provider had followed their plan and to confirm they now met legal requirements. We found that appropriate action had been taken and that legal requirements had been met.

We undertook this inspection to look at the overall quality of the service, and to provide a new rating for the service under the Care Act 2014.

The home is registered to provide accommodation for up to 20 older people who require assistance with personal care, some of whom may be living with dementia. On the day of the inspection there were 17 people living at the home, including one person who was having respite care. The home is situated in the centre of the village of Preston, close to the City of Hull and in the East Riding of Yorkshire.

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. The registered manager is also the registered provider of this service.

During this inspection we identified three breaches of regulation; this related to the risks associated with the safety of the premises and the prevention and control of infection. You can see what action we told the registered provider to take at the back of the full version of the report.

The home was not being maintained in a safe condition. There was no current gas safety certificate in place and had found this to be the case at the previous inspection. In addition to this, the contractor who serviced the home's bath hoist had stated that the stair lift needed to have a repair carried out within three months, and this had not been actioned.

The communal areas of the home and bedrooms were being maintained in a clean and hygienic condition. However, we saw that the seat on the only bath hoist in use was damaged to the extent it could not be kept clean. The two boilers in the laundry room were located in the 'clean' area but the tops were rusty and therefore difficult to keep clean. Both of these issues created a risk of cross infection.

Although the registered manager monitored the quality of care and support provided, we saw that areas that had been identified as requiring improvement had not been actioned. This meant that the quality monitoring systems at the home were not effective.

People told us that they felt safe whilst they were living at Oak Tree House. People were protected from the risks of harm or abuse because the registered provider had 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. Staff also told us that they would not hesitate to use the home's whistle blowing procedure if needed.

On the day of the inspection we saw that there were some staff vacancies but the rotas were being covered by existing staff to ensure people's individual needs were met. The recording of recruitment and selection information needed to be more robust to evidence that all safety checks were in place prior to staff commencing work. We made a recommendation about this in the report.

Staff confirmed that they received induction training when they were new in post and told us that they were happy with the training provided for them. Staff had received training on the administration of medication and people told us they were happy with how they received their medicines.

People told us that staff were caring and that their privacy and dignity was respected. People confirmed they received the support they required from staff and said that their care plans were reviewed and updated as required. Staff encouraged people to make decisions and have choice and control over their daily routines.

People were supported to access healthcare services. We saw that advice and guidance from healthcare professionals was incorporated into care plans to ensure that staff provided effective care and support.

People's nutritional needs had been assessed; people told us they were happy with the food provided and were consulted about the menu.

People told us they were able to raise concerns or make complaints although they had not needed to. They felt their suggestions were listened to.

We saw there were good relationships between the registered manager, people who lived at the home, staff and relatives / friends. This led to a homely, relaxed atmosphere.

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 safe.

There was a lack of evidence that the premises had been maintained in a safe condition.

The boilers in the laundry room and the seat on the bath hoist could not be kept hygienically clean and this posed a risk of cross infection.

Staff had received training on safeguarding adults from abuse and moving and handling. This helped to protect people from the risk of harm.

There were sufficient numbers of staff employed to meet the needs of people who lived at the home, and staff had been recruited following the home's policies and procedures, although some records were difficult to locate.

People received their medicines at the times they needed them and in a safe way.

Is the service effective?

Good

The service was effective.

We found the provider understood how to meet the requirements of the Deprivation of Liberty Safeguards (DoLS).

Staff undertook training that equipped them with the skills they needed to carry out their roles.

People's nutritional needs were assessed and met, and people told us they were happy with the meals provided by the home.

Is the service caring?

Good

The service was caring.

People who lived at the home and their relatives told us that staff were caring and we observed positive relationships between people and staff on the day of the inspection.

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

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

Is the service responsive?

Good

The service was responsive to people's needs.

People's care plans recorded information about their previous lifestyle and their preferences and wishes for care and support.

Visitors were made welcome at the home and people were encouraged to take part in suitable activities.

People told us that they had no concerns or complaints and they would not hesitate to speak to staff or the registered manager if they had any concerns.

Is the service well-led?

Requires Improvement

The service was not always well-led.

There was a registered manager in post.

Quality audits were being carried out to monitor that people were provided with care and support that met their individual needs. However, the quality monitoring system was not effective as identified improvements had not been carried out.

There were sufficient opportunities for people who lived at the home, staff and relatives to express their views about the quality of 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 was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection took place on 18 February 2016 and was unannounced. The inspection team consisted of one adult social care (ASC) inspector.

Before this inspection we reviewed the information we held about the home, such as notifications we had received from the registered provider, information we had received from the local authorities who commissioned a service from the registered provider and information from health and social care professionals. The registered provider was asked to submit a provider information return (PIR) prior to the inspection; this is a document that the registered provider can use to record information to evidence how they are meeting the regulations and the needs of people who live at the home.

On the day of the inspection we spoke with three people who lived at the home, two members of staff, a visitor, a health care professional and the registered manager.

We looked around communal areas of the home and bedrooms (with people's permission). We also spent time looking at records, which included the care records for three people who lived at the home, the recruitment records for two members of staff and other records relating to the management of the home, including staff training, the administration of medication and quality assurance.

Requires Improvement

Is the service safe?

Our findings

On the day of the inspection we checked that the premises were being maintained in a safe condition. We saw there were maintenance certificates in place for the fire alarm system, fire extinguishers, emergency lighting, the emergency call system, the electrical installation and portable appliances. The gas safety certificate expired on 11 February 2016; the registered manager told us that they would arrange to have the gas systems serviced as soon as possible. At the inspection on 8 January 2015 we had also found that the gas safety certificate had expired; it was serviced on 12 February 2015. At the time of writing this report we had not received a copy of an up to date gas safety certificate.

We saw that the 'mini' hoist, the bath hoist and the stair lift had been serviced in October 2015. We noted that the maintenance certificate for the stair lift identified a fault. The report stated that the stair lift could remain in service but repairs were required within three months; these repairs had not been carried out. The registered manager contacted us after the inspection to assure us that work to rectify this had been arranged. The downstairs bathroom was 'out of action' as the bath hoist was broken and needed to be replaced. This left only one bathroom for the people who lived at the home to access.

This was a breach of Regulation 15 (1)(e) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 which states that the premises and equipment must be properly maintained.

The manager had written a report on the prevention and control of infection. We saw the audit that had been carried out in April 2015. This was scored to identify the level of compliance; there was a score of 100% for hand hygiene, catheter care, the use of personal protective equipment (PPE) and the development of policies and procedures. The action plan recorded that one en-suite toilet needed new flooring, that the hallway carpet needed to be replaced by August 2015, that the lounge and dining room carpets needed to be cleaned by July 2015 and that staff needed to complete infection control training by August 2015. We noted that the hallway carpet had been replaced but the lounge and dining room carpets had not been cleaned and there was no evidence that staff had completed infection control training. There were plans in place for the flooring in the identified en-suite toilet to be replaced.

Soluble red bags were used to transfer soiled laundry into the laundry room and then into the washing machine; this helped to control the spread of infection. We saw that the laundry room had been divided into 'clean' and 'dirty' areas although there was no signage to identify this. The floor and walls were easily cleanable. However, we saw that there were two hot water / heating boilers in the clean area of the laundry room and the tops of both boilers were rusty and difficult to keep clean. The registered manager said it was not possible to paint the tops until the better weather, as they would not be able to turn off the boilers to paint them. They agreed this work would be carried out as soon as the weather was warm enough.

We saw that personal protective equipment (PPE) was readily available for staff. Toilets, bathrooms and some other areas of the home were supplied with liquid soap, hand gel and paper towels, and posters to advise on safe hand washing were displayed above wash basins.

People had their own toiletries that were kept in their bedrooms; this reduced the risk of cross infection. There were arrangements in place to respond to any outbreak of infectious disease, including signage to request that people did not visit the home until there had been a period of 48 hours without any new cases.

There was a domestic assistant on duty each day of the week and we saw there were appropriate cleaning schedules in place.

We saw the maintenance certificate for the bath hoist in the upstairs bathroom recorded that, although the hoist was safe to use, it needed to be fitted with a new seat. We saw that the seat was worn and uneven and therefore could not be kept clean. This posed the risk of cross infection.

This was a breach of Regulation 12 (2)(h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 which states that care and treatment must be provided in a safe way for service users.

People told us that they felt safe living at Oak Tree House. One person told us, "Yes, there are always people around and the doors are locked." We asked staff how they kept people safe and their comments included, "We look for hazards" and "We use equipment safely."

The staff who we spoke with told us they had completed training on safeguarding vulnerable adults from abuse, and this was demonstrated in the training records we saw. They were able to describe different types of abuse, and they told us that they would report any incidents or concerns they became aware of to the registered manager or a senior member of staff. One member of staff told us that they were due to attend refresher training on this topic the following week. In addition to this, the registered manager had attended a 'Train the Trainer' course and this meant they would be able to provide training on safeguarding adults from abuse in-house.

Prior to the inspection we contacted the local authority safeguarding adult's team and they told us that alerts were submitted appropriately by the registered manager. Copies of any safeguarding alerts submitted to the local authority by the home had been retained, and we saw copies were included in the person's care plan.

We saw that care plans listed the risks associated with each person's care and support needs. People had risk assessment in place about mobility, the risk of falls, pressure area care, the bedroom environment and nutrition. Other risks were identified that were more specific to the person, such as the use of the stair lift and the provision of bed rails. Risk assessments recorded the identified risk, who may be harmed and how harm could be prevented. Care plans included information about the mobility needs of each person and the details of any equipment they needed to mobilise. We saw care staff assisting people to mobilise on the day of the inspection and noted that this was done safely.

We saw that accidents and incidents had been recorded. The registered manager told us that accident forms were held in care plans and would be analysed by the key worker when they carried out monthly evaluations. Each year the accident forms for each person who lived at the home would be analysed again as part of the quality report, along with fluid charts, positional charts and 'as and when required' (PRN) medication charts. Body maps were available so that any bruises, sore areas, skin tears or fractures could be recorded. Body maps help care staff to monitor the person's recovery from any accidents or injuries.

People's care plans included details of their medical conditions and their current prescribed medication. People told us they understood why they were taking their medication and they received their medication at the right time.

We saw a list in the quality assurance folder that showed twelve members of staff were responsible for the administration of medication and that they had all completed appropriate training; we spoke with a care worker who confirmed they had completed this training. The registered manager told us that one of the domestic assistants, who had previously worked as a care worker at the home, was in the process of carrying out this training. This meant there would be an extra member of staff who could administer medication in an emergency. We saw a medication competency checklist in the quality assurance folder that had been devised by the registered manager and was due to be put into practice.

We saw that medication was stored securely; the trolley was fixed to the wall just outside the medication cupboard and it was locked when not in use. The temperature of the area where the medication trolley was stored and the medication fridge were taken each day and were seen to be within the recommended parameters. We saw that products or external and internal use were stored separately. The date was recorded on the packaging of eye drops when it was opened to ensure that they were not used past the expiry date; we discussed how it is recommended that all packaging (apart from the monitored dosage system) was dated when it was opened.

Some people at the home had been prescribed controlled drugs (CDs). These are medicines that have strict legal controls to govern how they are prescribed, stored and administered. We checked a sample of medication stored in the CD cupboard against records in the CD book and found that these balanced.

We checked the book where medication administration record (MAR) charts were stored and saw that each person had a laminated sheet in place that recorded their name and included a photograph. The registered manager told us they were in the process of producing new laminated sheets that would also include any allergies that the person had. Although these were currently recorded on MAR charts, this would make this information clearer for staff. Most handwritten entries had been signed by two members of staff, but not all. This double checking reduces the risk of errors occurring when information is transferred from the original packaging to the MAR chart. If any medication was discontinued, this had been recorded on the MAR, including who gave this instruction. We did not see any gaps in recording.

Some people had been prescribed 'as and when required' (PRN) medication and this medication was recorded on a separate MAR chart that was signed when this medication had been administered. In addition to this, people had a 'supplementary information' sheet in place that recorded the protocol for any PRN medication that had been prescribed. This recorded the name of the medication, the strength, the form (for example, tablet or liquid), the dose, any special instructions, the reason the medication had been prescribed and when the medication should be administered.

There was a 'reducing or escalating' dose sheet where staff recorded any changed in a person's prescribed dose of medicine; this acted as a 'second check' to ensure any changes in a person's prescribed medication were known by staff. There was an audit trail to ensure that medication prescribed by the person's GP was the same as the medication provided by the pharmacy. The arrangements in place for returning unused medication to the pharmacy were satisfactory.

We checked the recruitment records for two members of staff. We saw that an application form had been completed and checks had been made with the Disclosure and Barring Service (DBS). The Disclosure and Barring Service carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults. This helps employers make safer recruiting decisions and helps to prevent unsuitable people from working with children and vulnerable adults. The records we saw showed that some people had started work prior to all of their safety checks being in place. The registered manager assured us that new staff 'shadowed' experienced care workers whilst they were waiting for these safety checks to be

carried out but there was insufficient evidence in records to support this. The registered manager acknowledged that more robust recording needed to take place to ensure that these records evidenced that safe recruitment practices had been followed. We saw that a record of interview questions and responses had been retained for future reference. Staff were provided with job descriptions; this ensured staff were aware of what was expected of them.

The 'standard' staffing levels were three care staff on duty throughout the day and two care staff on duty overnight. On the day of the inspection we saw there were three care staff, a domestic assistant and a cook on duty, in addition to the registered manager. The registered manager told us that they had recruited staff and for the last few months they had been fully staffed. However, over the last few weeks several members of staff had left the home [for a variety of reasons]. The registered manager was in the process of recruiting again and in the meantime staff were working additional hours to cover shifts; the registered manager was covering shifts, one of the domestic staff had been working as a care worker instead of carrying out their domestic duties and some staff had cancelled their annual leave. We checked the staff rota and it was difficult to check if these staffing levels had been maintained, as some of these anomalies had not been recorded on the rota. The registered manager agreed that, in future, they would record these changes on the rota to evidence safe staffing levels.

Although staff rotas were covered, staff told us that they did not have much time to spend chatting with people. People who lived at the home told us that they "Could do with more staff now that there were more people living at the home." However, people were aware that efforts were being made to recruit more staff. They added that staff "Never grumble" and "Answer the buzzer quickly."

We recommend that the registered provider checks and adheres to published guidance on the safe recruitment of staff.

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.

Deprivation of Liberty Safeguards [DoLS] are part of the MCA legislation which is designed to ensure that the human rights of people who may lack capacity to make decisions are protected. 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. One person's care plan recorded that they had a DoLS authorisation in place and we saw that the documentation in respect of the DoLS authorisation was satisfactory. Discussion with the registered manager and staff indicated that they understood the principles of this legislation and how it applied to people who lived at Oak Tree House.

People's care plans recorded when a relative had power of attorney (POA) in respect of a person's affairs, although we did not see copies of the authorisation documentation. A POA is someone who is granted the legal right to make decisions, within the scope of their authority (health and welfare decisions and / or decisions about finances), on a person's behalf. It was not clear in the care plans we saw if representatives had POA for health and welfare, or for the person's financial affairs. We saw that a form was sent to relatives before Christmas to ask them to update an information sheet to make sure the home had current information about the person and their own role as power of attorney (POA).

Staff told us that they helped people make decisions by explaining choices and offering alternatives. Care plans we reviewed recorded a person's capacity to make decisions, that any decisions made on the person's behalf should be made in their best interest and that people should be involved in the decision making process as far as is possible. One care plan recorded, "I am very aware of my (medical condition) and the limitations it creates in my life. I understand the need for exercise and medication but have the capacity to make the decision to refuse both." This showed that there was an understanding that people who had capacity to make decisions might make unwise decisions.

People told us they could make decisions about their day to day lives, such as what time to get up and go to bed, and where they would like to spend the day.

We saw that staff asked for people's permission or consent before they started to support them. People who lived at the home confirmed this. One person said, "Yes, they do really" and another told us, "Staff ask before assisting me – they don't just jump in." Support plans recorded a person's consent to staff administering medication, having a photograph taken for inclusion in their care plan and to the content of their care plan. One person told us they had been prescribed some new medication and that they experienced adverse side effects. They had refused to take the medication and a relative had taken them to see their GP. This showed that the home had listened to the person's opinion when they said they did not want to take this medicine.

We asked people if they thought staff had the skills they needed to carry out their roles and to assist them with their care and support needs; they all responded positively. Their comments included, "One or two – you can tell they have had more training than the others. They are all good though" and "Yes, they are always on courses."

We saw the induction training records for two new members of staff. This included the topics of equality and diversity, health and safety and the use of equipment. However, records were not robust and did not include training certificates, so it was difficult to confirm which topics had been covered, the details of any shadowing shifts and when these had taken place. The registered manager acknowledged this and told us that any new staff would be required to undertake the Care Certificate. The Care Certificate is an identified set of standards that health and social care workers are expected to adhere to in their daily working life.

Staff had completed training that equipped them to carry out their roles. The quality assurance folder and updated training matrix included information about training that had been completed during 2015; such as sensory deprivation, nutrition and food handling, mental health awareness, equality and diversity, dementia awareness, end of life care and safe handling of medicines. The registered manager said that 75% of day and night care staff had now completed medication training. One member of staff had completed the Care Certificate since they had been employed at the home and one person had commenced a Level 3 Diploma in Health and Social Care. We asked a member of staff what training they had completed in the last year. They told us they had done "A lot of e-learning" including dementia awareness, medication and safeguarding adults from abuse. They said they had attended training on moving and handling the previous year.

We checked the training records for one member of staff; these recorded that they had completed induction training plus training on safeguarding adults from abuse, fire safety, use of the hoist and safe handling of medication, and that they had achieved a Level 2 and 3 diploma in Health and Social Care. However, there were no certificates available to evidence this.

Staff told us they attended regular one to one supervision meetings with the registered manager. They told us that they were able to "Say what they thought", make suggestions and discuss their training needs at these meetings. The registered manager told us they aimed to have formal meetings every two to three months and that she made sure she saw all staff over a two week period. She told us she sometimes arrived at work at 6.00 am or over the weekend so she could see staff who did not work day time shifts, Monday to Friday.

People told us they enjoyed the meals at the home; they said that they particularly enjoyed the breakfasts and lunches and that there was a choice of meal at lunchtime. One person said that tea time meals were "A bit boring" and another person said that some meals were better than others. This was being dealt with by the registered manager; people had been asked to make suggestions for tea time menus. One person told us that they had suggested they had more salad and the following day the manager had brought salad in for the tea-time meal. This showed that people's suggestions were listened to. We saw that the cook spoke to everyone in the afternoon to ask them what they would like for tea, and we noted various choices were offered.

We observed the lunchtime experience; we noted that there were condiments and paper napkins on tables. There was a menu on display; this recorded that the main meal was liver and onions and that an alternative was available. People were provided with a clothes protector if they requested one. One person was provided with a pureed meal and required assistance to eat their meal; this was done on a one to one basis so the person received the attention they required to take a good diet. People were asked if they would like

more vegetables, and were asked if they would like dessert. Some people chose to have a hot drink and some people chose a cold drink. One person chose to have their meal in the lounge and others chose to eat in their rooms; their meals were taken to them on a tray. We noted that the atmosphere was relaxed and friendly and that people stayed in the dining room after the meal to chat.

People had nutritional assessments and risk assessments in place and were also weighed as part of nutritional screening. We saw that advice had been taken from health care professionals when eating and drinking had been identified as an area of risk. One person's care plan recorded, "Following advice from the GP, SALT (Speech and Language Therapy team] and stroke nurse, [Name] is only to be given a 5ml amount of fluid from a syringe or a teaspoon in one go. They can have drinks from a feeder beaker but again only in small amounts." People told us their special dietary requirements were known and met. We saw that there was a board in the kitchen that recorded people's special diets and their likes and dislikes, such as "White toast, well done."

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. Five is the highest score available.

When we read people's support plans we gained a clear understanding of each person's medical condition, the reason medication had been prescribed, how the person was able to manage aspects of their physical and mental health condition themselves and the level of support they required from staff and health care professionals.

Records we saw on the day of the inspection indicated that health and social care professionals were involved appropriately in supporting people to maintain their health and well-being. These included GPs, chiropodists, opticians and dentists. Any contact with health and social care professionals was recorded in their care plan. A relative told us they were confident that family would be told if their family member was unwell, and that they were always kept informed of events at the home.

A review of care plans recorded that a new summary sheet had been introduced in place of patient passports; this included more information than the patient passport and could be taken from the care plan so people could take a copy with them to hospital appointments and stays. This would provide hospital staff with important information about how the person needed to be cared for when they were unable to verbally communicate their needs to them.

A care worker told us they would inform the registered manager or one of the staff who had responsibility for the administration of medication if they felt someone was unwell and needed to see their GP. They were confident that the GP would be called. People told us that staff would contact a GP on their behalf. One person said, "Staff would ring the GP for me" and another person said, "My son takes me to the surgery." A health care professional told us that staff asked for advice appropriately and followed that advice. They gave an example of someone with a pressure sore; staff were advised to help with person to change position every two hours and the health care professional told us that staff adhered to this consistently to ensure the person received appropriate care.

People who lived at the home told us they did not have any problems mobilising around the home. There were signs to identify toilet doors but we discussed how additional signage would help people to find their way around more easily. However, none of the people who we spoke with identified this as a concern. Because one bathroom was 'out of use' this meant there was only the bathroom on the first floor available for use. There were stair lifts to enable people to reach the first floor of the premises so that they could use

the bathroom.

Good

Is the service caring?

Our findings

We asked people who lived at the home if they felt staff really cared about them and they all responded positively. Comments included, "Some of them do – I can tell the way they handle me. Some would do anything for you", "Some seem to care and they are friendly, but they are tired" and "Oh yes, you can tell as soon as you meet them." Staff told us they were confident that the full staff team cared about the people they were supporting. One member of staff said, "Staff do really care – you couldn't do this job if you didn't." A health care professional and a relative who we spoke with confirmed this. They told us, "I have no concerns about this home."

We saw that interactions between people who lived at the home and staff were positive; it was clear that there was rapport between them and that staff understood people's particular personalities, behaviours and support needs.

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

We asked people who lived at the home if staff respected their privacy and dignity and they confirmed that they did. One person said, "I never thought I would need this help but staff do respect my privacy and dignity" and another said, "Yes, they are pretty good." A care worker described to us how they respected privacy and dignity; this included covering people to protect their modesty and talking to them and asking their permission. This showed that staff understood the need to respect people's privacy and dignity.

The registered manager told us that they had recently organised a 'Dignity in Care' day. This was a 'pamper' day. They said they did not have a dignity 'champion' but all staff were considered to be 'dignity ambassadors'.

Staff told us they tried to encourage independence and that they helped people with the things they could not do, such as rinsing their hair. People who lived at the home confirmed this. One person told us, "I get myself up – I can get up when I'm ready." One person told us they liked to 'set' the tables at meal times and we saw them carrying out this task on the day of the inspection.

We asked people if staff shared information with them appropriately and took time to explain things to them. One person said they did not get a lot of information but "There is always a notice about activities." Some staff lived locally and they were able to keep people up to date with village events.

We saw that the topic of confidentiality had been discussed at the staff meeting in December 2015. The registered manager reminded staff that they should not give out personal information about any person

who lived at the home over the telephone. They also reminded staff that they should not answer the telephone if they were busy over lunch time, as people at the home had a 'protected' lunchtime, and that they should not answer the telephone if they were responsible for the administration of medication.

The registered manager told us that there was information available to advise people about advocacy services. She had identified that two people who lived at the home would benefit from being supported by an Independent Mental Capacity Advocate (IMCA) and was in the process of trying to arrange this support.

We saw that some people had 'Do Not Attempt Cardiopulmonary Resuscitation' [DNAR] notices in their care plan and that these had been completed appropriately. Care plans recorded a person's wishes in respect of how they would like to be cared for at the end of their life. The registered manager told us that they made every effort to care and support people at Oak Tree House until the end of their life, if this was their wish. On the day of the inspection we saw that health care professionals were consulted appropriately when people were considered to require palliative or end of life care, and that people and their relatives were treated with empathy, respect and sympathy.

Good

Is the service responsive?

Our findings

Assessments were undertaken to identify people's support needs and records evidenced that this information had been gathered from the person themselves, their family / friends and from health and social care professionals involved in the person's care. People who we spoke with were not certain whether they had been involved in developing their care plan. However, one person told us their relative had prepared some information about their life history for the care plan and another person told us that there had recently been involved in a care plan review. Information gathered in assessments was used to develop support plans that outlined how the person's assessed needs were to be met. Areas covered included communication, eating and drinking, mobility, pressure area care, continence, personal care, emotional care, safety, night care, health needs and leisure / occupation / religious needs.

It was clear from reading care plans that care was focused on the person concerned. They were written in a person-centred way and recorded the person's individual needs and abilities under the heading 'Important things to know about me'. This information included details of the person's preferred name, the people who were important to them, their medical history and their hobbies and interests. We noted that care plans recorded what people were able to do without assistance, and the areas of care where they would require assistance. One person's care plan recorded, "The bath hoist is needed for me to get into and out of the bath. I do need a carer to be with me and like them to sit and chat to me." There was also a care summary that was used as a quick reference for care staff. We saw that staff had signed a record in each care plan to show that they had read the content.

We saw that care plans were evaluated each month and that these records included clear information about any changes to a person's care needs and therefore their plan of care. The registered manager told us in the PIR that people had a key worker who was responsible for ensuring their care plan was up to date; this was confirmed by people on the day of the inspection.

Staff told us that they kept up to date with people's changing needs through handover meetings at the start of each shift, by reading the care plans and by checking the communication book. We saw the sheet that staff used to record information discussed at handover meetings. This evidenced that every person who lived at the home was discussed so that staff had up-to-date information about their care needs. This system ensured that care workers had the information they needed to provide responsive care as people's needs changed.

We noted that care plans contained information about people's wishes and views and we observed staff supporting and encouraging people to make decisions and have choice and control over their lives. Comments from staff included, "We might offer two options with explanations to help people make decisions" and "We explain their choices – we know what they like."

Staff told us that they supported and encouraged people to maintain contact with their family and friends, and we saw that visitors were made welcome at the home. Staff told us they helped people to use the telephone if they needed assistance to contact family and friends. We saw that a letter had been sent to all

relatives before Christmas that included a satisfaction survey and an invitation to the home's Christmas party. A form was included with the letter that asked relatives to update an information sheet to make sure staff had current information about their family member.

There were two entries in the quality assurance folder recording information about activities that took place at the home. The activities included dominoes, jigsaws, reminiscence and manicures / hairdressing. We saw that there was a hairdresser at the home on the day of the inspection and several people had their hair done. Three males spent time in the dining room playing dominoes. One person told us that visitors from the church had been at the home the previous day and they had enjoyed singing hymns. The home had introduced an 'afternoon tea' event that was to be held each Thursday; we saw that there were leaflets about this displayed within the home stating that "All were welcome."

We saw numerous cards and letters that had been sent by people who had stayed at the home or their family / friends to express their thanks and satisfaction in respect of the care that had been provided.

Group meetings were not held for people who lived at the home, although one to one meetings had taken place to ask people for their views about the home's menus. We discussed how these individual discussions needed to be recorded so there was a note of the areas discussed and any agreements reached. People who lived at the home had also received a survey about meal provision at the home. One person who lived at the home told us they had been asked to make suggestions for ideas for tea-time meals and that some of their suggestions had been added to the menu. Another person had suggested that staff should wear a name badge, and we saw that this had been actioned.

People told us they would speak to the registered manager or staff if they were not happy with any aspect of their care, and that they were confident they would be listened to. One person said, "I could speak to the manager [Name] or my link worker."

We saw that the complaints procedure was displayed in the entrance hall of the home. Staff told us that they would make every effort to deal with minor complaints themselves, but anything more serious would be passed to the registered manager to action. They were confident that any issues raised would be dealt with in line with the home's policy and procedure. One member of staff said, "The manager listens – she would try to put it right." Any complaints made to the home were recorded, investigated and responded to.

Requires Improvement

Is the service well-led?

Our findings

We asked for a variety of records and documents during our inspection. We found that most of these were well kept and stored securely, including people's support plans and other documents relating to people's care and support. However, some information was difficult to locate and the registered manager told us she would forward this to us following the day of the site visit; some was forwarded to us but an updated training matrix, an updated gas safety certificate, evidence of a new employee's verbal references and evidence that the chair on the stair lift had been repaired was not forwarded to us.

We checked the folder that contained information about quality assurance. The registered manager had carried out an audit on hospital admissions, the frequency of falls, hospital / GP appointments, care plans and activities. The 'falls' audit recorded that one person had been referred to the falls team as they had fallen three times and as a result they had been re-referred for physiotherapy. The hospital / GP analysis recorded the number of telephone calls to the GP surgery and how many of these calls resulted in a visit from the GP. However, this information was not dated so it was difficult to determine the time period involved.

The audits carried out by the manager had highlighted some of the concerns we identified, such as the lounge carpet requiring a deep clean and the seat on the bath hoist needing to be replaced. However, we concluded that quality audits were not effective as the work identified in audits as requiring attention had not been actioned.

This was a breach of Regulation 17 (2)(a)(d)(i) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 which states that governance systems should assess, monitor and improve the quality and safety of the services provided and that records relating to persons employed at the home should be maintained securely.

The quality assurance folder also included information about a survey that had been carried out with people who lived at the home in November 2015 on the topic of menus. People were asked if they would like any new foods to be added to the menu and suggestions included pasta bakes, smoked fish, belly pork and a large pork pie. Suggestions for tea-time included omelettes and quiche. The registered manager told us that some of these dishes had been added to the menu.

A relative survey had been carried out in December 2015. This asked questions about the friendliness of staff, the complaints procedure, satisfaction with the care provided and "Do you think we could do better?" The survey advised relatives that staff were planning a 'Thursday afternoon drop-in' and asked them to suggest suitable activities. We saw that the comments in the returned surveys were positive, such as "My husband and I have never had any reason to complain."

The registered provider was required to have a registered manager as a condition of their registration, and the service had a manager who was registered with the Care Quality Commission (CQC); the registered manager was also the registered provider. On the day of the inspection we saw that the current CQC ratings

were displayed in the entrance area of the home, as required by legislation. This meant that the registered provider was meeting the conditions of their registration.

Services that provide health and social care to people are required to inform the Care Quality Commission (CQC) of important events that happen in the service. The registered manager had informed the CQC of significant events in a timely way. This meant we were able to check that appropriate action had been taken.

The registered manager told us in the PIR that they made sure they saw each person who lived at the home at least five times each week. On the day of the inspection our discussions with the registered manager evidenced that she had a very good knowledge of each person's individual needs. People who lived at the home and staff told us that the home was well managed. A member of staff told us that the registered manager was "Down to earth – you can discuss things with her – she is approachable."

We asked staff about the culture of the service. They described it as, "Friendly staff, a brilliant staff team – everyone gets on." One person who lived at the home told us "There is a very nice atmosphere."

A care worker told us they attended staff meetings. We saw the minutes of meetings held in April 2015 and December 2015. At the April meeting the topics discussed included the 'on call' rota, medication (including gaps in MAR charts), housekeeping, toiletries and care plans. Topics discussed at the December meeting included new staff rotas, mobile telephones (i.e. that staff should not carry them around whilst they are at work), infection control, training, Christmas and dignity. The registered manager gave staff several examples of how they should respect a person's dignity, including not shouting information about a person across the room and storing disposable gloves and wipes in a drawer rather than them being on display.

Staff told us they were confident that they would learn from any investigations that highlighted areas for improvement. The registered manager had received information about a serious case review held by a local authority as a result of a choking incident. They had carried out a review with all staff at the home and concluded that staff would act appropriately if someone started to choke. This showed that the registered manager had been proactive in checking out staff's knowledge about how to deal with this type of emergency situation.

Some new policies and procedures had been devised; these included policies for 'Dehydration; causes, signs and symptoms', 'Fire Emergency Evacuation Plan and Fire procedure' and 'Risks associated with catheter care'. We also saw an advice document from the Alzheimer's Society about 'UTI's and Dementia'. This showed that the registered manager had obtained good practice guidance from reputable sources and had amended the home's policies and procedures to reflect these.

The registered manager told us there were two moving and handling 'champions'; champions are staff members who take responsibility for a certain aspect of care practice and then share good practice with their colleagues. The moving and handling 'champions' at Oak Tree House had met with an occupational therapist to reassess everyone who lived at the home to ensure the slings that were used for transferring people with the mobility hoist were suitable for the person's needs.

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People who use services and others were not protected against the risks associated with the prevention and control of infection.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The premises and equipment used by the service provider were not being properly maintained.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems to assess, monitor and improve the quality and safety of the services provided were not operated effectively. Records relating to persons employed at the home had not been maintained securely.