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Oak House Residential Care Home

Inspection report

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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?	**Good**
Is the service well-led?	**Requires improvement**

Overall summary

The inspection took place on 19 October 2015 and was unannounced.

Oak House Residential Home provides accommodation for up to fourteen people. On the day of our inspection there were eleven people living at the home. The home is for older people, a small minority of whom are living with dementia or have learning disabilities. The home is a large detached property spread over three floors with two communal lounges, a dining area and a garden.

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

Summary of findings

registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People's safety could have been compromised as there were not effective, documented systems to monitor and audit the quality of systems and processes in place around medication administration and accidents and incidents. Audits ensure that any trends and areas for improvement are identified and used to drive change.

Confidentiality in relation to the storage of records compromised people's privacy. Records were not stored in a secure way and people's private information could have been accessed by other people who didn't have the authority to see it.

Decisions had been made on behalf of people as they were considered to not have capacity to consent to their care and treatment, however there were no formal mental capacity assessments undertaken to determine that they did not have capacity to make their own decisions about their care and welfare. The Mental Capacity Act 2005 is designed to protect and enable people who lack capacity to make specific decisions and ensures that they are at the centre of the decision making process. People had not had their mental capacity assessed in line with this legislation.

Where a person had bed rails in place, documentation did not confirm if they consented to the bed rails or if they were implemented in their best interest to keep them safe.

Recruitment procedures had been followed and staffing levels were sufficient to meet people's needs and people felt that there was adequate staff to support them. One person told us "Staff are always there for you". Staff were suitably qualified and had access to regular training to ensure that their knowledge and competence was current. However staff did not take part in formal supervision meetings according to the organisations policies and procedures, and they did not have access to any appraisal processes to review their practice and development. We have made a recommendation about referring to good practices in supervisions and appraisals.

People did not have access to call bells to call for assistance from staff if needed, people were not aware that they had call bells in their rooms that they could use if they needed to.

We have made a recommendation about following good practices in risk assessing.

People told us that they enjoyed the food that was offered in the home, the staff had received guidance from a dietitian and nutritionally balanced meals were offered to meet people's nutritional requirements. There was evidence that a person's health and nutrition had been improved as staff had followed advice provided by a dietitian. However we found that although staff were following advice from professionals and demonstrating good practice they were not always recording this and therefore there weren't clear records for staff to follow in relation to people's diet and nutrition. For people who had been assessed as being at risk of malnutrition, effective action had been taken to improve this but this had not been recorded, there were no records of the person's fluid or food intake and therefore staff lacked oversight as to the person's intake throughout the day.

We have made a recommendation about the monitoring of peoples weights and food and fluid intake.

Organisational policies were not up to date and didn't reflect current legislation, therefore staff were not provided with relevant information in order for them to support people in line with legal requirements.

Care plans were comprehensive and provided detailed information about the person's medical needs, these were person centred (social care approach which focuses on people having choice and control in their life) and informed staff of the person's likes and dislikes and life history.

However there were no advanced care plans in place for people to make their wishes known in regards to what they would like to happen at the end of their life. We have made a recommendation about following good practices in relation to advanced care plans.

People told us that they felt safe living at the home, that staff spent time with them, were caring and that the care they received was good. One person told us "Staff are all very good, I just feel safe here". People were supported by staff who had undertaken induction and on-going

Summary of findings

mandatory training in relation to safeguarding adults at risk and were able to confirm their knowledge and understanding when we spoke to them. People also had access to complaints procedures and understood how to make a complaint should they need to. Medication was managed and administered safely and accidents and incidents had been recorded appropriately.

People told us they were happy living at the home. We undertook observations of staff interactions with people throughout the day and this confirmed that people seemed to be happy with the support being offered to them. There was a friendly, homely atmosphere and staff were seen to be caring and compassionate. They supported people in a respectful and dignified way and people confirmed that their dignity and privacy were maintained.

We found a number of 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.

Summary of findings

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

Oak House Residential Home was not consistently safe, how risks are identified and managed needs to be improved. .

Staffing levels were sufficient to meet people's needs, people were protected from abuse, harm and discrimination by staff who were safe to work within the sector and who had undertaken relevant training.

Medication administration was safe and people received their medications correctly and on time. However these were not effectively monitored or audited to recognise errors and drive improvement.

Is the service effective?

Requires improvement

Oak House Residential Home was not consistently effective.

People's mental capacity had not been assessed when there were concerns that they lacked capacity to make specific decisions.

Staff were knowledgeable about the people in their care, and were suitably trained to deliver care effectively. However staff were not provided with formal supervisions of appraisals.

People were supported to maintain a healthy diet and told us that food at the home was good. People's health care needs were met.

Is the service caring?

Requires improvement

Oak House Residential Home was not consistently caring.

Advanced care plans were not in place for people to make their wishes known in regards to how they wanted to be cared for at the end of their life.

There was a friendly, homely atmosphere and people felt that the staff were friendly and caring. People were encouraged to express their views, they were asked for their feedback and were involved in decisions affecting the home.

Staff were caring and engaged with people. People were valued and staff understood the need to respect their individual wishes and values. Privacy and dignity was upheld when staff were offering support with peoples care needs.

Is the service responsive?

Good

Oak House Residential Home was responsive to people's needs. People's individual needs and preferences were assessed and care was provided in line with their care plans.

There were complaints policies and procedures in place that had been adapted to ensure people could understand these. People were aware of how to make complaints and were confident that they would be listened to

Summary of findings

Is the service well-led?

Oak House Residential Home was not consistently well-led.

The provider promoted a positive culture that was centred on people's needs but quality assurance processes were not always effective, or used to drive service improvement.

Organisational policies and procedures had not been updated for some time and did not reflect current guidance or legislation and therefore staff were not provided with appropriate up to date information to ensure that people were cared for in line with legislative requirements.

Requires improvement

Oak 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 the 19 October 2015 and was unannounced.

The inspection team consisted of three inspectors.

On this occasion we did not ask the provider to complete a Provider Information Return (PIR). 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. Before the inspection we checked the information that we held about the service and the service provider. We used this information to decide which areas to focus on during our inspection. During our inspection we spoke with four people, two care staff, the deputy manager and the registered manager.

We reviewed a range of records about people's care and how the service was managed. These included the care records for four people, medicine administration record (MAR) sheets, seven staff training and support and employment records, quality assurance audits, incident reports and records relating to the management of the service. We observed care and support in the communal lounges and dining areas during the day. We spoke with four people. We also spent time observing the lunchtime experience people had and a member of staff administering medicines.

The service was last inspected in January 2014 and was fully compliant.

Requires improvement

Is the service safe?

Our findings

People told us they felt safe living at the home. One person told us "I just feel safe here, there are plenty of staff and they look after us well". However we found that not all aspects of the service were safe.

A call bell system was installed in people's bedrooms and bathrooms, however when we spoke to people they were unaware that they had call bells in their rooms. One person told us "I don't think I have a call bell in my room". When we asked the registered manager about how people were able to call for assistance if needed. They explained that people were able to walk freely around the home and were therefore able to seek support from staff if needed. They explained that during the night regular checks were undertaken by staff to ensure that people were safe, however there was no evidence to support this. When we raised a concern regarding people being able to call for help who had impaired mobility due to ill health or for those who were using bed rails the registered manager was unable to explain how these people would be able to call for assistance.

Due to the absence of mechanisms in place to ensure people weren't isolated in their rooms and people being unable to use their call bells this posed a potential risk to people's safety and well-being during the night.

We recommend that the provider considers current good practice guidance in relation to risk management and access to call bells for people who are unable to independently mobilise.

There were low incidences of accidents and incidents and our observations found people to be cared for in a safe way. People felt that staffing levels were sufficient and this was confirmed when we looked at staff rotas, the registered manager explained to us that she took into consideration the needs of people when she first devised the rotas, ensuring that people's needs and abilities were assessed and sufficient numbers of staff allocated to meet those needs. She explained that this is monitored and if people's needs change such as if they are unwell or at the end of their life then she will ensure that more staff are working to meet people's needs. There was a full complement of staffing, people had worked at the home for many years and covered shifts for one another if there were holidays or sickness and no agency staff had been used for several years. Consistency within the staff team had helped ensure that people were cared for and supported by staff that knew them well and were able to identify any changes in people's health needs or their well-being. One person told us "Staff know what I like, they know me well", another person told us "I speak to the staff daily and they are able to tell if I am poorly".

People were supported by staff that were suitable to work within the health and social care sector. Measures had been taken when recruiting staff to ensure that they were safe to work with people and that they had the necessary skills and experience. Employment history had been checked and suitable references obtained. Further measures to ensure people were protected from abuse were taken as staff had undertaken training on Safeguarding Adults at Risk. This was regularly updated so that they were aware of the signs and symptoms to look for if they were concerned for a person's safety. Staff we spoke with were also able to confirm that they were aware of how to recognise and respond to abuse as well as how to report it. There was a small staff team that monitored people's safety and shared information when necessary. People living at the service had access to a complaints procedure and staff had access to a whistleblowing procedure if they had any concerns. A safeguarding alert had been raised for a person who lived at the home regarding concerns for her safety when she was accessing another service, this showed that there was vigilance over the person's well-being and that the registered manager had taken the necessary action to ensure that the person was safe when they were out of the home.

Positive risk taking helps ensure that staff are not risk averse and promotes a culture of positive risk management to enable people to live their lives how they want to and promote their rights and freedoms. People were supported to undertake positive risk taking in some aspects of their lives, for example, one of the risk assessments had identified a risk to a person who liked to go outside to smoke, this person had the capacity to make a lifestyle choice in relation to smoking, however risk in relation to how they accessed the garden was recognised, to minimise the risk of a fall, hand rails had been installed to ensure that the person could safely access the garden. Other examples of positive risk taking related to people freely walking around the home and up and down the stairs.

Requires improvement

Is the service safe?

Risk assessments were reviewed regularly and took into consideration the perceived extent of the risk, the likelihood of the risk occurring and the measures in place to minimise the risk. Suitable measures had been taken to ensure that people were safe but their freedom was not restricted unless the person lacked capacity to make decisions about their safety. Risks associated with the safety of the environment and equipment had been appropriately identified and managed. Regular fire checks had been undertaken and people living at the home all had personal emergency evacuation plans so that staff were aware of how to support each person to evacuate the building in the event of a fire. There was also a business continuity plan in place to ensure that in the event that the home could not be used due to an emergency that there was a place for the people to stay until they could return home. Regular health and safety checks had been undertaken to ensure the safety of water temperatures, food hygiene, electrical equipment, and safe storage of chemicals.

People were asked if they would like to take their medication and were supported to take this in a timely and safe manner. Staff had received training on medication administration and we observed medication being administered in a safe and competent way. The member of staff retrieved the medication from a locked cabinet, gained the persons consent before supporting them and ensured that they had a drink to take their medication. Records to show that the person had taken their medication were updated. There were safe systems in place for the ordering and disposal of medication.

Requires improvement

Is the service effective?

Our findings

People told us that staff were good at what they did. Staff were sufficiently skilled and experienced to care and support people to have a good quality of life, they had received induction training and regular mandatory training to ensure that their practice and skills were up to date, staff members had also undertaken Diplomas in Health and Social Care. One member of staff explained that when they were first employed that they didn't have any experience within health and social care, however undertook a three month induction and accessed relevant training to ensure that they were competent. However we found that not all aspects of the service were effective.

Staff had a good understanding about mental capacity and deprivation of liberty safeguards, they were able to explain to us why these were in place for people that lived at the home, records showed that they had attended training for these and this had a positive impact on people as we observed staff asking people for their consent before offering support to them. However formal consent processes were not followed.

Care plans and safeguarding records for two people stated that they did not have the capacity to make decisions or be involved in the development of care plans or to consent to a safeguarding alert being raised. When we asked the registered manager how their capacity had been assessed she told us that this was based on staff's knowledge of the person's abilities. The Mental Capacity Act 2005 (MCA) is designed to protect and enable people who lack capacity to make specific decisions and ensures that they are at the centre of the decision making process. The MCA 2005 is decision specific and the person should be assessed to determine that they can retain, weigh up, understand and communicate the decision. For mental capacity assessments to be completed in line with legal requirements, they must adhere to the code of practice and legislation.

The provider had made applications to the local authority for Deprivation of Liberty Safeguards (DoLS) for two people who lived at the home. These safeguards protect the rights of people by ensuring if there are any restrictions to their freedom and liberty that these have been authorised by the local authority as being required to protect the person from harm. These related to people being unable to leave the home on their own due to risks to their safety and well-being. However we were advised by a member of staff that one person, who lacks capacity sometimes used bed rails at night to prevent them from falling out of bed. There was no assessment in place to indicate that the use of bed rails was the least restrictive intervention needed to manage the individual risk. When we raised this with the registered manager this was dealt with immediately and a risk assessment was written. The use of bed rails is also a restriction on a person's freedom and liberty if they are unable to consent to their use. There was no mental capacity assessment or best interest decision making process undertaken for this person in line with The Mental Capacity Act 2005 and no Deprivation of Liberty Safeguards (DoLS) application made. The registered manager confirmed that this person was unable to consent to the use of bedrails. This demonstrated that this person may have had their freedom of movement unnecessarily restricted without due consideration to their abilities to consent or whether this was in their best interest.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

In addition to the mandatory training offered to staff they were encouraged to access training courses that were specific to the needs of the people who lived at the home, for example training courses about Dementia awareness and Learning Disabilities, records confirmed this. Staff were observed and monitored to ensure that they were demonstrating competence and therefore the training that they had undertaken had been implemented into their practice and they were supporting people effectively.

Staff explained that they communicated daily with the registered manager and felt that they could approach them if they had any concerns. However the provider had a supervision policy that stated that staff should receive supervision six times per year. Staff records showed that no members of staff had received supervision for over a year. When we spoke to staff they told us that they felt adequately supported. The registered manager recognised that formal supervision had not been undertaken for the past year, but explained that as a small team communication was undertaken on an informal and frequent basis. The Social Care Institute for Excellence (SCIE) warns that although this type of informal supervision may enable a supervisor to deal with an immediate need, it may lead them to making rushed decisions and actions. It

Is the service effective?

also warns that there is a danger that this type of supervision is not recorded and that issues raised within supervisions are not carried forward to the next formal supervision. This is something that we found to be the case. When we discussed a member of staff's conduct with the registered manager she told us that she had raised the issue with the member of staff before, however as this had not been documented there was no formal way of recording this issue and therefore no evidence to confirm that this had been raised on more than one occasion. When we asked the registered manager about her supervision she told us that this again is informal and that no formal supervisions with the provider of the service take place. However support is available to her should she require it. Without formal supervision, issues such as the registered managers learning and development, her management and oversight of the service and staff members conduct were not monitored.

Appraisals were not carried out. The SCIE advises that the ultimate goal of providing supervision and appraisal is to improve the outcomes for people. Without having supervisions and appraisals in place there was a risk that performance issues were not addressed and dealt with in a timely and sufficient manner which could have led to peoples outcomes being affected.

We recommend that the provider refers to best practice guidance in relation to regular formal supervision and appraisals.

People told us that they were happy with the food in the home, one person told us "The food is great, I eat every bit I am given and am always offered seconds". At lunchtime we observed people having their lunch, sandwiches were placed on the table and there didn't appear to have been any choices offered to people. However one person had previously told us "I have to order my choice of food before my meal". Another person told us "I eat what they put in front of me"; however people we spoke with confirmed that they were happy with the food available. One member of staff told us "People are not asked what they want for dinner on a daily basis but will be given an alternative if they don't like the food, for example one person doesn't like pasta so we may offer a jacket potato instead".

The atmosphere throughout lunch was relaxed and there was gentle music playing in the background, people were observed enjoying the food and conversation with staff.

After their lunch people were offered pieces of fruit for their dessert. People were able to choose where they ate their meals, some chose to be in the main dining room whereas others preferred to eat their lunch in their own room.

People were encouraged to have a balanced diet, menus confirmed this and included fresh vegetables and fruit. Two people living with dementia had been assessed as being at risk of malnutrition, their care plans provided information to staff about their nutritional requirements and contained dietetic reports that informed staff of the actions that they needed to take to ensure that they had adequate nutrition. One of these reports advised staff to offer cups of tea to a person after they had eaten their meal as the person had been drinking vast amounts of tea before meals and this was affecting their appetite, we were able to see that staff had implemented this recommendation and as a result the person's appetite had increased and they had not lost any more weight. Another person's dietetic report had recommended that they be given fortified meals and snacks, staff confirmed that full fat milk, milk powders and butter were added to the person's meals. However this person was often declining their food, evidence that efforts had been made to liaise with other health professionals such as GP and the Dietitian to support the person to eat was recorded in their care plan.

Food record charts can provide the essential information that forms the basis of a nutritional assessment and helps determine subsequent treatment plans. However there were no fluid or food charts for the people that were at risk of malnutrition and therefore there was no monitoring or oversight of what a person was eating on a daily basis. Both people had lost weight, however one of these people had not been weighed regularly, there were several months where the person hadn't been weighed, this showed that people at risk of malnutrition were not adequately monitored to ensure that they were not losing more weight.

There were regular health care checks to ensure that peoples overall health and well-being was monitored and maintained. These included visiting GPs, dentists, dietitians and dementia in-reach teams. This was confirmed as one person told us "If I am poorly, staff will contact the GP for me". Another person told us that they had seen the Chiropodist when they visited the home.

The home was laid out over three floors, the floors were accessed by staircases and people were able to move

Requires improvement

Is the service effective?

independently around the home, if someone's mobility deteriorated then they were able to move to a room on the ground floor if one became available. There were adequate spaces within the home to enable people to mix with others or spend time on their own if they so wished. People also had access to the garden and handrails had been installed to ensure people could access this area independently and safely.

Requires improvement

Is the service caring?

Our findings

People were treated with kindness and compassion, one person told us "Staff are really nice, I get along with all of them, and they are available to assist me if needed". Relatives had been asked for their opinions about the home through an annual survey, one relative said "I would not want my relative anywhere else. Genuinely lovely, caring staff, very friendly and a family atmosphere". Another relative said "A warm, welcoming and caring environment, clearly this home is run for the benefit of the residents, a happy place". However we found that not all aspects of the service were caring.

We were able to see that staff had received end of life care training and one member of staff told us that they would seek support and advice from a district nurse if a person needed end of life care support. Another member of staff told us that people were able to remain at the home and were supported until the end of their life. According to the Social Care Institute for Excellence(SCIE) people with dementia should to be supported to make an advanced care plan, this means discussing and recording their wishes and decisions for future care, it is about planning for a time when they may not be able to make decisions for themselves. SCIE advise that providers of homes also need to ensure that they are prepared for situations and do their best to ensure that they know, document and meet the person's wishes at the end of their life. Advanced care plans were not in place for the people living at the service, these were only devised when someone was nearing the end of their life. Not having an advanced care plan in place could potentially mean that a person is cared for in a way that is against their wishes if they do not have the capacity to make their feelings known at the time.

We recommend that the home consider current guidance on advanced care planning so that conversations with people about their preferences at the end of their life can take place.

Staff interactions with people were positive. Staff explained their actions before supporting people and also ensured that people were addressed using their preferred name and that they adapted and used the communication method that best met the person's needs and abilities. Written communication in the form of easy read documents were provided to the people with learning disabilities and for people living with dementia practical strategies were used to support their memories. Interactions were relaxed and friendly and staff were observed using appropriate humour with people to create a social atmosphere. People appeared to enjoy the interaction with staff and it was apparent that staff knew the people well, they spent time with people talking about their day and asking how they were and engaged in conversations with them about things that were important to them. For example we observed one member of staff speaking to a person about their family, this person was living with dementia and therefore sometimes repeated what she was saying, the member of staff demonstrated patience and understanding and continued to enable the person to talk and express her feelings.

The registered manager told us that staff had worked at the home for a long time, they were compassionate, loved their jobs and cared for the people that lived there. We were able to see evidence of this. For example one person became anxious as they couldn't remember when they had last spoken to their family, we were able to see a member of staff recognise the signs of this person's anxiety and spend time with them talking and listening. The member of staff suggested to the person that they start to write down the dates and times that they had spoken to their family on a small blackboard, so that if the person couldn't remember then they could check this and be reminded. This appeared to have a really calming effect on the person and after the interaction the person was able to settle and their anxiety was greatly reduced. This demonstrated good practice and was in accordance with guidance produced by the Alzheimer's Society which advises that staff should take time to listen to people's feelings and show patience and understanding when supporting people who are experiencing signs of distress or anxiety. In one person's care plan there was guidance for staff from an external psychotherapist, advising the staff to enable the person to express their feelings and to spend time with them listening.

People's privacy and dignity in regards to their support needs were maintained, people told us that staff knock on their doors before entering rooms and observations confirmed this. We were also able to see that people were asked discreetly if they needed support with their personal hygiene and a member of staff told us that that they always close the door whilst supporting a person with their

Requires improvement

Is the service caring?

personal hygiene needs. Two people who lived at the service chose to lock their bedroom doors, they had their own keys for their rooms which helped to ensure that their privacy was respected.

Care plans reflected that people's differences were respected, information about the person's life history was included and used to inform staff of people's interests and hobbies. People were able to express their religious beliefs and staff offered support to one person to attend church. Adaptations had been made to information and care plans to ensure people had equal access to these and were fully informed and could be involved as much as they were able.

The ethos of the home, is to promote people's independence as much as possible. People were able to retain the skills that they had and were able to be as independent as they could be in regards to their personal hygiene needs, one person told us "Staff are available to assist if needed".

People did not have a formal advocate, instead they were supported by their family members, key workers or their day centres but external advocacy services could be contacted and these had been involved in peoples care in the past.

Good

Is the service responsive?

Our findings

People had confirmed in the last resident's survey that they had been involved in the development of their care plans. The registered manager told us that "For those that can be involved in their care plan review they're encouraged to do so, we will also gather information from family or other professionals if a person cannot be involved due to their understanding". Care plans showed that two out of the four people had been involved in the development of them, for people living with dementia and for those with a learning disability care plans had been adapted to meet their communication needs, for example pictures were used to promote understanding. Care plans were comprehensive and clearly detailed the person's medical needs, preferences and support needs. There were sections within the care plan called 'Me and my life' this included information about what was important to the person, for example, friends, family, hobbies and interests, we were able to see this information used in practice as people were able to choose to undertake activities and pass times according to their wishes and preferences.

Dependent on the person's needs staff had completed a Disability Distress Assessment Tool (this helped to identify distress cues in people who because of their cognitive impairment or physical illness have limited communication). This assessment informed staff of the signs to look for that might indicate if a person was distressed. We saw staff recognising a person's distress through their behaviour and facial expressions and offering support to them..

People's individuality was respected, within the care plan for one person is stated that this person liked to wear a certain item of clothing and doesn't like to be cold and that staff needed to ensure this was available for this person. We saw the person wearing the garment and they told us that they liked wearing it as it kept them warm. We were able to look in people's bedrooms, these were furnished with people's own furniture and possessions showing that people were able to choose how to decorate their own personal space.

The National Institute for Health and Care Excellence (NICE) recommends that older people should be encouraged to construct daily routines to help improve or maintain their mental well-being. We were able to see evidence of this as two people were supported to spend the morning at a local garden centre, whilst another person was away on holiday with a local charity that specialises in providing leisure activities and holidays for people with learning disabilities. People confirmed that they were able to do what they wanted with their time. One person told us "Some people go to day centres, I don't want to go, and I am happy doing my jigsaw puzzles and reading my books". Another person told us "I join in with the activities when I want to, I enjoy watching TV". We were later able to see the same person undertaking general cleaning and dusting which they appeared to enjoy. The activities programme showed that people were able to access local day centres, places of worship, bowles, arts and crafts, creative writing and undertake gentle exercise.

Feedback from people was positive and was used to inform practice and change and therefore improve the care provided. We were able to see minutes of regular resident's meetings and annual surveys from people, relatives and health professionals. People were able to make complaints and were made aware of this through a complaints procedure that was clearly displayed and adapted to help ensure people's understanding. People's awareness of their right to make a complaint was confirmed as one person told us "I would speak to the manager if I wanted to make a complaint". People were made aware of their right to complain when they first moved into the home. There was also a comments and suggestions box and a telephone number people could use if they wanted to remain anonymous when raising a complaint or concern. There had been no complaints made since our last inspection and one person told us "They look after us well; I have nothing to complain about". We were able to see the summary of results for the people's, relative's and health professional's survey that was sent out last year which summarised that 'complaints were made, although rare were dealt with immediately and culminate in the complainant being satisfied with the information and outcome'.

Requires improvement

Is the service well-led?

Our findings

People indicated that the home was well led. One person told us "They do everything well, I'm happy with the home." Another person told us "They look after all of us, everything they do is fantastic". However we found that not all aspects of the service were well led.

There was a statement of purpose that set out the provider's intentions to provide a homely home, develop personal skills, independence, and build confidence and self-esteem. During our inspection we were able to see that they had been successful in implementing this statement of purpose and the registered manager confirmed this and told us "It is a homely, happy home, their home, there is lots of laughter and it is run in a family orientated way." We spoke to three members of staff, they confirmed that the home was well led. One member of staff told us "They are good managers, very good to staff, we are encouraged and appreciated for our hard work".

However, despite people's positive feedback, we found areas of practice which required improvement, some quality assurance was undertaken by the registered manager to measure and monitor the standard of the service provided. However the registered manager did not have a robust quality assurance system and those that were carried out were not clearly documented. For example there had been a recent medication recording error, one of the measures the registered manager had suggested needed to be put in place following this was to undertake weekly audits of the medication administration records (MAR). The registered manager confirmed that although these had been undertaken, they had not recorded the outcome of these to be able to analyse and monitor any trends, patterns and potential concerns and enable them to take appropriate action to make improvements. A range of quality assurance audits should take place within a service to ensure that the systems and processes used are effective, this also helps to identify areas of practice that need to improve and drives change.

Accidents and incidents had been recorded, one record showed that there had been an altercation between two people, staff had offered appropriate support by spending time diffusing the situation and encouraging the people to move to separate rooms. However, when we asked the registered manager how they monitored and analysed these to recognise trends, patterns and potential concerns they told us that they informally monitored these but confirmed that their monitoring was not recorded. Quality assurance is about monitoring and learning from situations to ensure that changes and improvements are made. We raised this with the registered manager who acknowledged that more robust and formal audits need to take place.

People's care plan folders were not stored in a confidential way, they were stored in cupboards in the main dining area, these cupboards were unlocked and therefore could have been accessed by other people living at the service and their visitors. Electronic records that were stored on the computer were also not secure, we were able to see the laptop showing confidential documents left unattended three times throughout the duration of our inspection, during one of these times one person attempted to use the laptop. The Data Protection Act 1998 states that people responsible for using data must make sure that the information is handled according to people's data protection rights and kept safe and secure. Staff records were also stored in unlocked drawers in the main living area. When we raised these concerns with the registered manager they informed us that the care plan folders can be accessed by people so that they can look at their care plans, although acknowledged that this does not happen and could mean that other people can have access to others records. They went on to explain that all computers were password protected to ensure that people couldn't access them who didn't have authorisation to, however acknowledged that on this occasion it had been left unattended and with documents left on the screen.

There was not an adequate process for assessing and monitoring the quality and safety of the services provided and for ensuring that records were kept secure. **This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.**

Part of a registered managers responsibilities under their registration with the Care Quality Commission is to have regard and read and consider guidance in relation to the regulated activities that they provide, as it will assist them to understand what they need to do to meet the regulations. One of these regulations relates to the registered managers responsibility to notify us of certain events or information. There had been an incident within the home that had been raised as a safeguarding alert to the local authority by an external professional. The registered manager had not notified us of this, by not

Requires improvement

Is the service well-led?

notifying us of incidents such as these we are unable to assess if the appropriate action has been taken and the relevant people alerted. **This is a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.**

The home had organisational policies that had been provided to staff within a staff handbook, these had been written in 2002. When we asked the registered manager how policies were updated, she explained that these were reviewed and updated every year, and if there were changes in legislation or guidance then she would update them. However we could not find evidence of how these policies had been reviewed and updated. Policies need to be updated to reflect changes in guidance and to ensure that organisations are complying with legislation. This had not taken place and as a result staff had out of date guidance that didn't reflect current legislation. For example policies were not updated and staff were not made aware of changes in relation to safeguarding since the Care Act 2014 and changes to the Deprivation of Liberty Safeguards since the Supreme Court Ruling in April 2015. Reviewing and updating organisational policies is an area that needs to be improved upon.

Records showed that some people living at the service had their finances managed by the registered manager. However we could not find any documents to support this, when we raised this with the registered manager they explained that it had been that way since they had started in post 13 years ago. That there were records in place from before this time showing that people had signed to say that they were happy for them to manage their finances. The registered manager acknowledged that this may have been the accepted practice when they first joined the home, however due to changes in legislation this needed to be reviewed. The registered manager explained that she would look into undertaking mental capacity assessments and pass on the responsibility to the local authority if after these assessments it was found that people lacked capacity to manage their finances safely. Reviewing dated practices in the management of peoples finances is an area that needs to be improved upon

The registered manager acknowledged the shortfalls and the areas for improvement in the service and the need to keep themselves up to date with best practices in the care and support of people living with dementia and learning disabilities.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 11 HSCA (RA) Regulations 2014 Need for consent **Regulation 11(1) (3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Need for consent.** **The registered person had not ensured that suitable arrangements were in place for obtaining and acting in accordance with the consent of service users or establishing and acting in accordance with the best interests of the service user in line with Section 4 of the Mental Capacity Act 2005.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance **Regulation 17 (1) (2) (a) (c) (d) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Good governance.** **The registered person had not assessed, monitored and improved the quality and safety of the services provided in the carrying on of the regulated activity (including the quality of experience of service users in receiving those services)** **The registered person had not maintained and secured accurate, complete and contemporaneous records in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided.**

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents **Regulation 18 (2) (b) (e) of the Care Quality Commission (Registration) Regulations 2009. Notification of other incidents.** **The registered persons had not notified the commission of any abuse or allegation of abuse in relation to a service user.**

The registered person had not maintained securely such other records as are necessary to be kept in relation to persons employed in the carrying on of the regulated activity or the management of the regulated activity.