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Oak House Care Home

Inspection report

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Axminster
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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

Summary of findings

Overall summary

This inspection took place on 17, 23 and 29 November 2016. The first visit was unannounced and the second visits were planned with the management team. Oak House is registered to provide care and accommodation for up to 17 people, some living with dementia. The home is grade two listed building situated in the town of Axminster. They provide care and support for frail older people and those people living with dementia. On the first day of our visit there were 16 people living at the service which included one person receiving respite support. On the second day of our visit another person had come to the home making 17 people at the service.

We carried out an unannounced comprehensive inspection of this service on 26 February 2015. Two breaches of legal requirements were found. These were regarding the safe management of people's medicines, accurate records and effectiveness of the quality monitoring of the service. At this inspection we checked to see whether the requirements had been met and found they had been addressed.

The registered provider is also the registered manager of the service. A registered manager is a person who has registered with Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The registered person had delegated the day to day running of the service to an acting manager. They had recognised that even with their regular visits to the home the acting manager who also undertook care shifts required additional support. The area manager worked at the home two days a week to provide support for the acting manager. Further changes are planned for the management of the home in the near future.

Staff did not always treated with dignity and respect and ensure their privacy was maintained. People were supported to eat and drink enough and maintained a balanced diet. Staff relationships with people were strong and supportive.

The acting manager was very visible at the service and undertook an active role. They were very committed to providing a good service for people in their care and demonstrated a supportive approach to staff. They were supported by a deputy manager and senior care staff. The management team were open, friendly and welcoming. The area manager and acting manager had recognised there were areas which required improvement. They were developing their roles and responsibilities and were delegating staff roles and responsibilities. The provider had purchased a new quality monitoring system. This had been put into place to continually review and improve the service. Where there were concerns or complaints, these were investigated and positive action taken.

People were supported by staff who had the required recruitment checks in place. However improvements were needed regarding ensuring employment gaps had been checked for staff employed using the new employment application forms used by the provider. Staff received an induction and were knowledgeable about the signs of abuse and how to report concerns. All care staff with the exception of one had undertaken

or were enrolled on recognised national qualifications in health and social care. However not all staff had undertaken refresher training of the provider's mandatory training. This had been recognised and training was being scheduled. The area manager had taken on responsibility to ensure there were adequate staffing levels at all times to meet people's needs.

Staff had a good understanding of what constituted abuse and how to report if concerns were raised. Measures to manage risk were as least restrictive as possible to protect people's freedom. Medicines were safely managed on people's behalf, with the exception of people's prescribed topical creams. However action was taken during the inspection to put in place a safer system to improve the recording of people's topical creams.

Care plans had been re-written in a new format which the provider had started to use. They were personalised and recognised people's social and psychological needs. However they lacked detail regarding people's behavioural needs and routines. People's and relatives views and suggestions were taken into account to improve the service. Health and social care professionals were regularly involved in people's care to ensure they received the care and treatment which was right for them.

The area manager demonstrated an understanding of their responsibilities in relation to the Mental Capacity Act (MCA) 2005. Where people lacked capacity they put in place during the inspection mental capacity assessments in line with the MCA. This was to ensure where they had made a best interest decision on a person's behalf they could demonstrate they did not have the capacity to make the decision themselves. However an incorrect DoLS application had been submitted.
The area manager worked with the acting manager to put in place appropriate applications to the local authority deprivation of liberties team where decisions needed to be made in peoples' best interests to keep them safe. Training has been scheduled for staff to receive further MCA and DoLS training

Staff supported people to follow their interests and take part in social activities. Two designated activity staff were employed by the provider and supported people at the service to take part in activities.

The premises and equipment were managed to keep people safe.

We found a breach of the regulations at this inspection. You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

People's medicines were being safely managed, with the exception of prescribed topical creams.

Improvements were needed to ensure there were safe and effective recruitment processes in place.

People were protected by staff who demonstrated a good understanding of what constituted abuse and how to report if concerns were raised.

The area manager ensured staff levels were adequate to meet people's individual needs.

The premises and equipment were being managed to keep people safe.

Is the service effective?

Requires Improvement

The service was not fully effective.

People were not adequately supported to make decisions about their care because staff did not fully understand or follow current legislation.

Staff had not received sufficient training or regular updates to enable them to meet people's needs effectively. This had been recognised and training had been scheduled. All care staff with the exception of one had or were working towards a higher qualification in health and social care.

Supervisions were being undertaken to enable staff to feel confident in meeting people's needs and recognising changes in people's health.

People's health needs were managed well through contact with community health professionals.

People were supported to maintain a balanced diet.

Is the service caring?

Requires Improvement

The service was not always caring.

People were not always treated with dignity and respect.

Staff spoke confidently about people's specific needs and how they liked to be supported.

People could be confident their visitors were always given a warm welcome.

People were able to express their views and be actively involved in making decisions about their care, treatment and support.

Is the service responsive?

Good

The service was responsive to people's needs.

Care plans were person centred about people's histories, wishes and social need.

Designated activity staff supported people to undertake a range of activities.

There were regular opportunities for people and people that mattered to them to raise issues, concerns and compliments.

Is the service well-led?

Requires Improvement

The service had not been well led.

An area manager had been appointed who was identifying where changes and improvements were needed, and taking action to address these. However improvements were still needed.

Staff spoke positively about the changes at the service and the improvement in staff morale. They said the management team worked well with them and there was good communication.

People, relatives and staff were being asked their views and these were taken into account in how the service was run.

There was an audit program being used to monitor the safe running of the service.

Oak House 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 was 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.

Oak House is registered to provide care and accommodation for up to 17 people, some living with dementia. The home is grade two listed building situated in the town of Axminster. They provide care and support for frail older people and those people living with dementia.

This inspection took place on 17, 23 and 29 November 2016 and the first day was unannounced. One adult social care inspector completed the inspection.

Before the inspection, we reviewed the information we held about the service from the Provider Information Return (PIR) which we received in November 2015. The PIR is a form in which we ask the provider to give us some key information about the service, what the service does well and any improvements they plan to make. We also reviewed other information we held about the service such as from notifications. A notification is information about important events which the service is required to send us by law.

We met and observed most of the people who lived at the service. The majority of the people using the service were unable to provide detailed feedback about their experience of life at the home. During the inspection we used different methods to help us understand their experiences. These methods included both formal and informal observation throughout the inspection. We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us. Our observations enabled us to see how staff interacted with people and see how care was provided. These methods included informal observation throughout the inspection. Following the inspection we contacted four relatives to ask them their views of the service.

We spoke with and sought feedback from 12 staff including the acting manager, deputy manager, senior care staff, the maintenance person, cook, and housekeeper. We also spoke with the registered manager who is also one of the directors, a director and the area manager.

We reviewed information about people's care and how the service was managed. These included two people's care records and five people's medicine records, along with other records relating to the management of the service. These included staff training, support and employment records, quality assurance audits, minutes of team meetings and findings from questionnaires that the provider had sent to relatives. We also contacted the health and social care professionals and commissioners of the service for their views. We received a response from two of them.

Requires Improvement

Is the service safe?

Our findings

People and their relatives said they felt it was safe at Oak House and they were well supported by staff. One person commented, "Oh yes I feel safe here, I would soon have something to say if I didn't." Relatives comments included, "He is very happy there"; "Safe and is well looked after" and "I am very happy, they have done brilliantly with (person). They cannot do more."

Improvements were needed to ensure the recruitment process was effective to ensure fit and proper staff were employed. There was a checklist used to ensure all documentation was being completed when employing new staff. The provider had employed two new staff using new recruitment paperwork. However the pages where staff would record their employment history had not been given to these staff and therefore their employment history had not been explored.

Pre-employment checks had been carried out, which included references from previous employers and Disclosure and Barring Service (DBS) checks. The DBS helps employers make safer recruitment decisions and prevents unsuitable people from working with people who use care and support services. This was to help ensure staff were safe to work with vulnerable people. Following the inspection we received confirmation from the area manager that they had the employment histories of the two staff and had checked for employment gaps. They also confirmed they had checked all recruitment files to ensure employment gaps had been explored.

Staff who administered medicines were trained and assessed to make sure they had the required skills and knowledge. It was not clear whether people had their prescribed topical creams administered as prescribed. A topical cream chart with a body map was in place. This guided staff which cream to use, where it should be applied and the frequency of the cream application. However staff had not always signed the topical cream charts. We raised this with the area manager and on the second day of our visit a new system was being trialled. Senior care staff had been told as part of their daily duties that they needed to check that all administrations of topical creams had been recorded accurately.

The deputy manager had been delegated to take responsibility of the medicines to ensure they were managed safely. They had ensured when the home received people's medicines from a local pharmacy on a monthly basis they had been checked in and the amount of stock documented to ensure accuracy. Medicines were kept safely in a locked medicine cabinet. The cabinet was kept in an orderly way to reduce the possibility of mistakes happening. A pharmacist had visited the service in October 2016 and completed a medicine's check. They had raised no significant concerns regarding the management of people's medicines at the service. Where they had made a suggestion regarding a medicine cupboard which required a more secure fixing, this had been completed.

The medicine fridge temperature was being recorded. However on the day of our visit there was concern about the temperature reading and its accuracy. The acting manager had taken action and contacted the local pharmacy who had advised they dispose of the medicine stored in the fridge and new ones were prescribed. On the second day of our visit the area manager said a new fridge had been ordered. While this

was being resolved medicines which required cold storage were being stored in a container in the kitchen fridge which was having it temperature monitored.

Where people had medicines prescribed on an 'as required' basis (known as PRN) protocols were in place about when they should be used. This meant that staff were aware of why and when they should administer these medicines to people appropriately.

Staff demonstrated an understanding of what might constitute abuse and knew how to report any concerns they might have. For example, staff knew how to report concerns within the organisation and externally such as the local authority safeguarding team, police and to the Care Quality Commission (CQC). The management team demonstrated an understanding of their safeguarding roles and responsibilities. The home was protected by coded security locks on the front door. To help maintain people's safety the access code for the building was regularly changed. This was so staff and visitors who no longer needed access were required to ring the bell and be let in by staff.

People were protected because health and falls risks for each person were identified and managed. Care records contained detailed risk assessments about each person which identified measures taken to reduce risks as much as possible. These included risk assessments associated with people's nutritional risk, pressure damage and falls risk. People had skin integrity risk assessments undertaken and appropriate equipment in place to meet their needs, for example pressure relieving mattresses.

Our observations showed there were sufficient staff on duty during our visits to meet people's needs and keep them safe. Staff were busy but had time to meet people's needs. The responsible person said they scheduled a senior carer with three care workers each morning. A senior care worker and two care workers were on duty each afternoon and evening and two awake care staff at night. These were supported by a cook, a housekeeper, activity staff and a maintenance person. There were no staff vacancies at the service at the time of this inspection. Two vacancies had just been appointed to. The acting manager said they were just awaiting recruitment checks for them to start. The staff and acting manager undertook additional shifts when necessary to fill gaps to ensure adequate staffing levels were maintained.

A Personal Emergency Evacuation Plan (PEEP) was available for each person at the service. This provided staff with information about each person's mobility needs and what to do for each person in case of an emergency evacuation of the service. People's individual emergency plans were held in their care records. There was also a grab folder which contained everybody's PEEP's and a single document held at the fire panel with a synopsis of people's needs for the emergency services if required. This showed the home had plans and procedures in place to safely deal with emergencies.

Accidents and incidents were reported. Staff completed an accident and incident form which contained the nature of the incident and the actions taken. The acting manager reviewed all accident and incident forms.

The accommodation felt homely and welcoming when we arrived. However on the first day there was an area in the main entrance which smelt malodourous. On the second day of our visit a carpet in a room off of that area which had been scheduled to be replaced had been fitted. The odour had gone and there were no unpleasant odours in the home. One relative commented, "The great thing about the home is that it doesn't smell." Daily cleaning schedules were used and staff used suitable cleaning materials and followed cleaning and infection control procedures. Staff used hand washing, and protective equipment such as gloves and aprons to reduce cross infection risks.

The provider had a program of redecoration underway. This included new sash windows which had needed

to be made as the home is a grade two listed building. They said they hope to complete this in 2017. They were also scheduled to have new carpets laid in communal areas and some new furniture.

The provider employed a full time maintenance person who oversaw maintenance at the service. They undertook regular checks and maintenance of equipment. These included monthly checks of the environment looking at window restrictors, water temperatures and furnishings. They also carried out fire drills weekly in accordance with fire regulations and checked fire extinguishers had not been tampered with. The acting manager had also undertaken an environmental audit regarding risk. These looked at all areas and included the catering facilities and computer work station. Where they had identified areas of concern these had been addressed. For example, where carpet strips were a hazard these had been replaced. The acting manager said "If drawers or doors are broken on client's furniture we get that sorted straight away."

External contractors undertook regular servicing and testing of moving and handling equipment, fire equipment, electrical and lift maintenance. A legionella assessment had been undertaken in March 2016 and stated no remedial action required.

Staff recorded required repairs and faulty equipment in a maintenance book and these were dealt with and signed as completed by the maintenance person. The area manager said they would be implementing a new format for recording maintenance issues. The new system would enable them to have a clearer view of maintenance issues and whether they had been addressed.

Requires Improvement

Is the service effective?

Our findings

People's consent for day to day care and treatment was sought by staff. However not all staff were clear about Deprivation of Liberty Safeguards (DoLS) and what responsibilities they had to protect people's rights. The area manager had recognised this and had arranged Mental Capacity Act 2005 (MCA) and DoLS training for staff. The MCA provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. For example, health professionals had been consulted about a best interest decision regarding the need to crush a person's medicines and place it in their food. On the first day of our visit mental capacity assessments had not been put in place to demonstrate that people lacked capacity before a best interest decision was made. However on the second day of our inspection everybody at the service had been reviewed and appropriate capacity assessments had been put into place.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). The Care Quality Commission (CQC) monitors the operation of the DoLS which applies to care homes. DoLS provide legal protection for those vulnerable people who are, or may become, deprived of their liberty. On the first day of our inspection one person had the incorrect application to the DoLS team for an urgent seven days cover which had expired. This meant that they were not under a DoLS application and yet their rights were being restricted. On the second day of inspection the area manager been working with the acting manager and had made an appropriate application and also made another urgent application for a new person at the home.

People's liberty was restricted as little as possible for their safety and well-being. For example, a careful assessment was undertaken whenever the use of bedrails was considered for the person's safety.

We recommend that the provider reviews the Mental Capacity Act 2005 to ensure all people's rights are maintained.

People's needs were not always met by staff who had the right competencies and knowledge. The area manager had recognised staff training as a priority as there were gaps in staff training requirements. They had delegated the responsibilities to the deputy manager to ensure all staff had received the provider's required training. Training on health and safety related topics undertaken included, food hygiene, safeguarding of vulnerable adults, infection control, health and safety and fire safety. Where gaps had been identified training had been scheduled to ensure all staff had received the required training and updates. Staff were positive about the training they had received. One staff member said, "I really enjoyed it (training)… a lot of detail, I learnt a lot." Another who had recently undertaken medicine training said how they had been supported to understand people's medicines and felt more confident. They explained how they had worked with the deputy manager to increase their knowledge and confidence. The area manager said that all care staff with the exception of one had, or were working towards, a higher qualification in

health and social care.

Staff had undergone an induction. Staff said they felt the induction had given them the skills to carry out their roles and responsibilities effectively. The provider had introduced and was working with staff to complete the new Care Certificate which had been introduced in April 2015 as national training in best practice.

The area manager said they recognised the importance of staff supervisions. Staff supervisions had been carried out but often on an informal basis. The area manager had arranged to meet with all of the staff to introduce themselves. They said their aim was for staff to have supervision every three months and an annual appraisal.

Staff ensured people were supported when required by a variety of health professionals. For example, the bladder and bowel advisor, speech and language team (SALT), dietician, optician and older people's mental health team. People had access to healthcare services for ongoing healthcare support. They were seen regularly by their local GP, and had regular health appointments with professionals such as dentist, optician, and chiropodist. Where any health concerns were identified, visiting health care professionals confirmed staff at the home sought advice appropriately. Their comments included, "they alert us promptly and are quite proactive in assisting us when we visit". The community nurse team were working with staff to assess their competence to administer insulin to a person with diabetes.

People and records confirmed the staff monitored people's health and care needs, and acted on issues identified. For example, where one person was appearing anxious and unwell they tested their urine and found they had an infection. They contacted the GP and antibiotics treatment was put into place.

People were supported to eat and drink enough and maintain a balanced diet. People were seen enjoying the food during our visits. We observed a lunch time meal in the dining room with others choosing to eat in the lounge or their room. People were advised about the menu option which was recorded on a large whiteboard. They had a choice of two meal options from a four week rotating menu. Staff were attentive to people's needs and responded quickly to requests. For example one person who liked their cup of tea in a certain way had five different cups of tea made for them until they were happy it was to their liking. People were able to dish out their own potatoes and vegetables from dishes on the tables.

Staff had gathered information about people's dietary requirements, meal sizes, likes and dislikes when they first arrived at the home. There was a list which identified people's dietary needs whether they were diabetic or required a soft consistency. Where people had any swallowing difficulties, they had been seen and assessed by a speech and language therapist (SALT). People at risk of weight loss had their weight monitored. During our visit we identified most people had maintained their weight.

Requires Improvement

Is the service caring?

Our findings

Staff did not always treat people with dignity and respect. On the first day we saw three examples during the lunchtime meal where staff were not interacting with people and respecting them. While staff were supporting people with their meals they were happily chatting amongst themselves about their own lunches and not including the people they were supporting. When one person asked a staff member to repeat the dessert option they were responded to sharply. A member of staff failed to respect a person's dignity by speaking about them in a negative manner to other staff within the person's hearing.

Staff did not always maintain people's privacy and dignity when assisting with intimate care. Where two people were sharing a bedroom, there was no means to screen either person when they were being repositioned or receiving personal care.

In people's rooms there was a care plan referred to as a 'carer plan' which guided staff regarding people's main needs. This was placed in a transparent holder in each room for easy access. However in the room where people were sharing their information was on display for relatives and visitors to see. We discussed these concerns with the area manager and acting manager.

This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities Regulations 2014.

On the second day of our visit action had been taken by the area manager and acting manager. They had moved the furniture around in the shared bedroom and a portable screen was in use to enable the two people to have their own personal space. On the third day of our visit a permanent curtain track had been put in place. They had moved the people's carer care plan into their individual wardrobes so it was not on display for visitors to read.

The area manager had arranged to have supervision's with staff who had been on duty on the first day to discuss training needs. The acting manager said they had spent time in the dining room since our first visit to observe staff interactions. On the second day we observed staff being polite and kind to people and engaging.

The registered manager took these matters seriously. They said they had recognised there had been problems and there had been recent staff changes. They planned to make changes to the management team to ensure problems with staff working practices and staff morale are addressed. As part of the area manager going to Oak House, two senior care staff had also transferred one to be the new deputy manager. We spoke to both of them and they said the staff morale had been very low but was improving. They told us that the area manager had allowed staff to wear their onesies (all in one pyjama's) to work on 'Children in need' day which had been really successful.

At other times during our visits, staff were friendly towards people and were seen positively interacting with them, chatting, laughing and joking. People appeared happy in their presence. Relatives said they felt the

staff were caring and kind. Their comments included, "Absolutely they are brilliant, particularly the staff. They care and show affection to all of the clients. They treat them like their own parents" and "They are marvellous. I find them patient and happy. When I am there the way they are with others is gentle and patient. I have never heard them be fractious they are very, very good."

Staff involved people in their care and supported them to make daily choices. For example, people chose the activities they liked to take part in, where they spent their day and the clothes they wore. Staff said they knew people's preferred routines such as who liked to get up early, who enjoyed a chat and who required reassurance and emotional support.

People's relatives and friends were able to visit when they liked. Relative said they were made to feel welcome when they visited the home. Comments included, "When I visit they always asked if I would like a drink and ask if I would like to stay for lunch."

People's rooms were personalised with photographs, pictures on the walls and ornaments. People's rooms were identified by the names of trees and a small plaque with their names on. We found this a little confusing when finding people's rooms. However staff and people were very good at knowing which room people used.

Good

Is the service responsive?

Our findings

People received personalised care and support specific to their needs, preferences and diversity. The provider's 'Philosophy of Care' states, 'As our Philosophy of Care, Oak House Care Home looks at the 'Whole Person' and not just part of a person. It is so important to identify each person individually in order to bring the right benefits for them'.

Before people came into the home a pre admission assessments was undertaken. A member of the management team had met with new people to ascertain their needs, views and wishes and to assess whether the service could meet their needs. The information gathered was then transferred to a care plan of how their needs were to be met. The plans included what mattered to the person and how they and their family could be supported. Staff also completed a 'Personal care needs assessment tool' which looked at the level of people's needs. For example, whether low medium or high dependency needs. This assessment took into account, communication, bathing, washing, dressing, grooming, continence, eating and drinking, pressure ulcer care and social recreational.

Care plans had been re-written using a new format which had recently been implemented by the provider. They were up to date and broken down into separate sections, making it easier to find relevant information, for example, personal care needs, communication, night needs, mobility and elimination. In one person's care plan staff were guided how to help the person maintain their independence. It stated, 'just guide (person) to where the toilet is. (Person) is able to take himself. Take time to answer questions. Due to (person) Alzheimer's do not rush him and wait for him to answer.' Staff said they were able to refer to the care plans when they recognised changes in a person's physical or mental health. People were given the opportunity to be involved in reviewing their care plans. People or their relatives where appropriate to do so were asked to sign the pre admission assessment and the monthly reviews. Relatives confirmed they were involved in reviewing their relatives care. One commented, "I chat to them (staff), I filled out forms with them. They asked for a precis of his life so they have something to talk to him about and take on board his hobbies and travel." Another commented, "Absolutely no complaints, their liaison with me is very good, they keep me informed."

We discussed with the area manager and acting manager that the care plans did not reflect people's behavioural needs and guide staff how to appropriately meet those needs. For example, advising staff regarding triggers which might cause a person distress or clearly identifying a routine which would give the person continuity. On the second day of our visit people assessed as having behaviours which were challenging had new care plans in place to guide staff. The area manager confirmed that they would be reviewing everybody's care plans to ensure people's behavioural needs had been addressed.

Care files included personal information and identified the relevant people involved in people's care, such as their GP, optician and chiropodist. Relevant assessments were completed and up to date, from initial planning through to on-going reviews of care. Staff said they were told about new people at the service at handover and had the opportunity to read the information contained in people's care files which enabled them to support people appropriately in line with their likes, dislikes and preferences. Care files included

information about people's history, likes and dislikes. This meant that when staff were assisting people they knew their choices, likes and dislikes.

Staff used a document called, 'Activities of daily living care' to record at least three times a day the support they had given to people. The area manager had been working with staff to improve the information they recorded to include people's general demeanour, how they were and presentation.
The provider had recorded on their website, 'We believe that social and leisure aspects of life are an integral part of care, which should be all about achieving maximum independence and helping people to have some fun'. In order to support people to achieve this they employed two activity staff who worked week days but were flexible with their time if activities were arranged at weekends. In the main entrance there were notices advertising a bingo evening and the Christmas party. On the second day of our visit four people had gone out in the provider's minibus on a magical mystery tour outing. They arrived back at lunchtime and all appeared to have had a good time. During our visits we saw several people go out into the community with a staff member on a one to one. This included a person who had become anxious about needing to go to the bank. The registered manager and acting manager took them on an outing and they were more relaxed on their return.

The provider's vision recorded on their website stated, 'We firmly believe in the importance of keeping clients as active and independent as possible.' People were supported to access their local community and keep in contact with friends and family. Throughout our visits people were being taken on outings of their choosing. One person liked to go the towns market. Relatives spoke highly about the activities at the home. Comments included, "I like it that they take (person) out most weeks. They have been to Otter Nurseries, West Bay and are going to Beer next week to see the Christmas lights. I like the fact they are not left there twiddling their thumbs"; "They try to get Mum to join in" and "Always lots going on there." One relative was very pleased that their relative went to the maintenance person's workshop with them. They said, "(Maintenance person) is a delightful fellow, he takes (person) to his workshop. It makes him feel at home. I am very impressed."

The provider had a complaints procedure which made people aware of how they could make a complaint. It also identified outside agencies people could contact which included, the local authority and the government ombudsman.

People and relatives said they would feel happy to raise a concern and knew how to. Comments included, "Yes if things got bad I would say something"; "Absolutely nothing to complain about" and "I told them about the laundry. They always try and sort it out. I am ever so pleased with Oak House. Every one of the staff are most helpful."

There had been one complaint received at the service in 2016. This had been investigated and responded to in line with the provider's complaints policy. As an outcome of the complaint actions had been taken to prevent further occurrences. Where the acting manager had been made aware of grumbles they had taken them seriously and had taken action to ensure people were happy and satisfied with the outcome.

Requires Improvement

Is the service well-led?

Our findings

The service had not always been well managed. The provider's had recognised improvements were needed regarding the management structure at the service.

The registered person was also the registered manager of the service. The registered person had delegated the day to day running of the service to an acting manager. However two months before our inspection they had recognised that, even with their regular visits to the home, the acting manager who also undertook care shifts required additional support. They planned to make changes to the management structure by appointing a new area manager who will support the acting manager while they develop their management skills. The area manager would work at the home two days a week and support the acting manager. They would help put in place systems and support the acting manager to develop their management skills. The registered provider said they were planning to take a less active role at the service. The intention was for them to deregister as the registered manager and the area manager and acting manager to apply to the Care Quality Commission (CQC) to become joint registered managers. As part of the changes two senior care staff had transferred from the provider's other home to work at Oak House. This was to bring their experience and for them to develop their skills in higher roles.

Before our inspection the area manager had identified some areas which required improvements and was working with the acting manager to implement these. These included medicine management, supervisions, meetings and training. They were both also responsive to our findings and took action to resolve them during the inspection process. However improvements were still required regarding areas of concern we identified. These included, ensuring people were treated with dignity and respect, care plans had the required detail to guide staff, ensuring new staff were fit and proper to work with vulnerable people and improved topical cream administration.

Staff spoke positively about how the acting manager had supported them in their roles. They said she was approachable, hardworking and had a strong ethos to deliver good care. They also spoke positively about the area manager and the changes and improvements at the home. They said there had been a low morale at the home which was now improving. Relatives said the acting manager was friendly and approachable. Comments included, "(Acting manager) is very decent, I find her easy to talk to always willing to listen and quite receptive"; "I can speak to (senior car worker) who is very good or (acting manager) who is great" and "Lovely lady, very kind and caring."

People's views and suggestions were taken into account to improve the service. The management team recognised the importance of gathering people's views to improve the quality and safety of the service and the care being provided. For example, resident and relatives meetings took place every three months to address any arising issues and the acting manager ensured they spent time with people on a regular basis. The last relatives and residents meeting held in October 2016 discussed the Christmas party. Someone had requested homemade Yorkshire puddings instead of bought ones. A staff member confirmed the week before our visit there had been homemade Yorkshires served. At the meeting people had been asked if they had received night time drinks and their views on call bell response time. All present confirmed they were

happy. People were informed about new carpets which were going to be fitted.

In addition, surveys had been sent to relatives and friends of people using the service in September 2016. The surveys asked specific questions about the standard of the service and the support people received. There had been eight responses so far and on the whole these were positive. The acting manager said they planned to collate the responses and they would take actions to address any issues identified. They said they would share the outcome of the survey by sending out a letter, discussing it at the next residents and relatives meeting. They also said they intended to start doing a monthly newsletter.

The service worked with other health and social care professionals in line with people's specific needs. People and staff commented that communication between them and the other agencies was good and enabled people's needs to be met. Care files showed evidence of professionals working together. For example, GP's, speech and language therapist and community psychiatric nurse. Health and social care professionals confirmed that the service worked well with them and took on board things requested.

Staff were consulted and involved in decision making about the service through regular staff meeting and said they felt listened to. There had been meetings held with the kitchen staff, care staff, senior staff and maintenance staff as well as whole team meetings. They said they planned to undertake a full staff meeting every three to four months unless a need arose to have an additional meeting. The records of the last staff meeting held in September 2016 discussed health and safety issues, reminded staff to read and sign the policies and procedures. Job roles had been discussed including the area manager's new role and that they would be at the home at least two days a week. They were also informed care plan training had been booked and that the area manager would be having supervision with all staff. The last meeting with the kitchen team in September 2016 discussed serving meals to enable people to have a better dining experience. We observed changes had been made with a notice board in the dining area to advise people of the meal choices and people being able to serve themselves. The acting manager said they were going to send a questionnaire to staff at the beginning of 2017 to ask them their views.

The senior team meeting held in November 2016 set out the roles and responsibilities of the senior staff. For example who was responsible for medicines, reviews and audits to be undertaken including wheelchair and bed and mattresses.

Staff had a staff handover meeting at the changeover of each shift where key information about each person's care was shared. This meant staff were kept up to date about people's changing needs and risks.

Staff had access to a range of policies and procedures to guide their practice, which were in the process of being reviewed and updated.

The provider had recently put in place a new quality monitoring system. This had been put into place to continually review and improve the service. The provider had started to use the new quality compliance system to help them with monitoring the service. There was a programme of monthly audits of the medicines, care plans, accidents and incidents, health and safety, infection control and activities. Following these audits actions were put in place and checks were undertaken to ensure they were carried out. For example, an activity audit found not all activities were recorded. This was addressed by putting in place a recording sheet to demonstrate activities people participated in.

In September 2016 the service was inspected by an environmental health officer in relation to food hygiene and safety. The service scored three with the highest rating being five. This meant there were immediate areas where improvements were required. They had identified three areas for immediate action, these

included the need to deep clean the tin opener and the seals on a fridge and food to be moved which was not stored appropriately in the fridge. Action had been taken by the provider regarding all three of these issues. We observed that the tin opener and fridge had undergone a steam clean and food was appropriately stored in the fridge. The area manager said they would be putting in place a cleaning schedule for the kitchen to ensure that all areas were cleaned regularly. The service was following a nationally recognised food hygiene guide known as 'Better food better business' to record temperatures as recommended by the environmental health officer. The file had been sorted and was in order. This showed the provider had listened to the environmental health officer and was working to ensure good standards and record keeping in relation to food hygiene.

There were accident and incident reporting systems in place at the service. The manager reviewed monthly all of the incident forms regarding people falling and completed an audit. The audit did not include patterns in regards to location or themes. However they said they were aware of all accidents and had a good understanding of patterns and themes.

The provider had displayed the previous CQC inspection rating in the main entrance of the home and on the provider's website. As far as we are aware, the provider met their statutory requirements to inform the relevant authorities of notifiable incidents.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The provider had not ensured that people were always treated with dignity and respect and their privacy was maintained. Reg10 (1)(2)(a)