Bupa Care Homes (BNH) Limited

Oakhill House Nursing Home

Inspection report

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Tel: 01403260801

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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?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

The inspection took place on 23 February 2016 and was unannounced.

Oakhill House Nursing Home provides accommodation for forty-nine older people, living with dementia, who need support with their nursing and personal care needs. On the day of our inspection there were forty-five people living at the home. The home is a large property, spread over two floors, situated in Horsham. There are four communal lounges, two dining rooms and well maintained gardens.

The service had not had a registered manager for six months. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. A manager had been in post since August 2015.

People's consent was gained before being supported to take their medicine. There were safe systems in place for the administration of medicines and records showed that people had received these on time. However, there were concerns regarding the procedures for covert medicine administration and the storage and disposal of some medicines. This is an area of concern.

People were supported to maintain their nutrition and hydration. People felt that they had enough food and drink and observations confirmed that drinks and snacks were offered throughout the day. People could choose what they had to eat and drink and felt that the food was good. For people at risk of malnutrition, appropriate measures had been implemented to ensure they received drink supplements. Foods were fortified with cream, milk and cheese to increase their calorie intake.

However, people's dining experiences varied. Staff supported most people to have a positive dining experience. They were supported in a sensitive and respectful way according to their needs. However, for a minority of people, their dining experience was poor. There was limited interaction from staff and people were not supported to eat and drink in a way that was conducive to them maintaining adequate nutrition and hydration. This is an area in need of improvement.

There were sufficient numbers of staff to ensure people's needs were met and their safety maintained. Staff had received induction training and had access to ongoing training to ensure their knowledge was current and that they had the relevant skills to meet people's needs. People were safeguarded from harm. Staff had received training in safeguarding adults at risk, they were aware of the policies and procedures in place in relation to safeguarding and knew how to raise concerns. People felt safe, one person told us "If I wasn't safe here I wouldn't tolerate it."

Risk assessments had been undertaken and were regularly reviewed. They considered people's physical and clinical needs as well as hazards in the environment and provided guidance to staff. Observations confirmed

that staff were aware of risk assessments and supported people in accordance with them. People were encouraged and enabled to take positive risks. People's independence was not restricted through risk assessments. Observations of people assessed as being at risk of falls showed them to be independently walking around the home. There were low incidences of accidents and incidents, those that had occurred had been recorded and were used to inform practice.

People were asked their consent before being supported with anything. Mental capacity assessments had been undertaken to ensure that for people who lacked capacity appropriate measures had been taken to ensure best interest decisions were made on their behalf.

People had access to relevant health professionals to maintain good health. Records confirmed that external health professionals had been consulted to ensure that they were being provided with safe and effective care. People's clinical needs were assessed and met. People received good health care to maintain their health and well-being.

People were cared for by staff who knew them and understood their needs and preferences. People told us that they felt well cared for. One person told us "They're brilliant, so helpful, I can't fault it."

People were involved in their care and decisions that related to this. People and relatives were asked their preferences when people first moved into the home. They were provided with an opportunity to share their concerns and make comments about the care they received. Relatives confirmed that they were involved in their loved ones care, felt welcomed when they visited the home and knew who to go to if they had any concerns. The provider welcomed feedback and was continually acting on feedback to drive improvements within the home.

People were treated with dignity and their rights and choices were respected. Observations showed people being treated in a respectful and kind manner. People's privacy was maintained, when staff offered assistance to people they did this in a discreet and sensitive way. People confirmed that they were treated with dignity and their privacy was maintained.

Staff knew people's preferences and support was provided to meet people's needs, preferences and interests. There was a variety of activities that people appeared to enjoy. People were able to make suggestions as to how they wanted to spend their time and these were listened to and acted upon.

There was a homely, friendly and relaxed atmosphere within the home. People were complementary about the leadership and management of the home and observations confirmed that the vision and ethos of the home was embedded in staff's practice. Staff felt supported by the manager and were able to develop in their roles. There were rigorous quality assurance processes in place that were carried out by the manager and provider to ensure that the quality of care provided, as well as the environment itself, was meeting people's needs.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The home was not consistently safe. There were concerns regarding the safe storage and disposal of some medicines.

There were sufficient numbers of staff working to ensure that people were safe, however there were concerns that there were insufficient staff to meet people's social needs.

People were asked to give their consent and they received their medicines on time. Medicines were dispensed by trained staff.

Staff were aware of how to recognise signs of abuse and knew the procedures to follow if there were concerns regarding a person's safety. The home was clean, systems were in place to reduce the spread of infection. Risks were assessed and the premises were safe and well maintained.

Is the service effective?

Requires Improvement

The home was not consistently effective.

People were supported to eat and drink to maintain their health. However, some people did not receive appropriate support to enable them to have a positive dining experience.

People's consent was gained before staff offered support. The provider had complied with relevant legislation when people, who could not give their consent, were deprived of their liberty.

People were supported to maintain good health. They had access to healthcare professionals to enable them to receive the necessary care and treatment.

Is the service caring?

Good

The home was caring.

People were supported by staff who knew their preferences and needs well. Positive relationships had developed and there was a friendly and warm atmosphere.

People were treated with dignity and respect. They were able to

make their feelings and needs known and able to make decisions about their care and treatment.

Is the service responsive?

Good

The home was responsive.

People received care that was in accordance with their needs and preferences. There were a variety of activities offered to people and people's interests were taken into consideration when offering support.

People were involved in their care. There were mechanisms in place to enable people and their relatives to comment and complain about the care people received.

Is the service well-led?

Good

The home was well-led.

People and staff were positive about the management and culture of the home. Quality assurance processes monitored practice to ensure the delivery of high quality care and to drive improvement.

People were treated as individuals, their opinions and wishes were taken into consideration in relation to the running of the home.

Oakhill House Nursing 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 23 February 2016 and was unannounced. The inspection team consisted of two inspectors and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

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 five people, three relatives and seven members of staff. After the inspection we contacted a GP and the local authority, who visit the home on a regular basis. We reviewed a range of records about people's care and how the service was managed. These included the care records for six people, medicine administration record (MAR) sheets, four staff training, support and employment records, quality assurance audits, incident reports and records relating to the management of the service. We spent time observing care and used the short observational framework for inspection (SOFI), which is a way of observing care to help us understand the experience of people who could not talk with us. We observed care and support in the communal lounges and dining areas during the day. We also spent time observing the lunchtime experience people had and the administering of medicines.

The service was last inspected in June 2014 and no areas of concern were noted.

Requires Improvement

Is the service safe?

Our findings

People told us that they felt safe and were able to talk to staff if they had any concerns. One person told us "If I wasn't safe here I wouldn't tolerate it." A relative told us "I would have no hesitation speaking to the manager about my relative, in fact any of them. You can just speak to anyone about anything." However, we found an area in need of improvement in relation to the storage and disposal of medicines.

People were assisted to take their medicines safely by registered nurses and trained care staff, that had their competence assessed. Medicines were not dispensed or administered during meal times to ensure that the risk of errors occurring was minimised. People's consent was gained and they were supported to take their medicine in their preferred way. Observations showed one person being supported to take their medicine. Staff asked the person if they were ready to take the medicine and if they had a drink. They explained what the medicine was and assisted the person to take their medicine in their preferred way. For example, the person liked staff to put their medicine onto a spoon and assist them to put it in their mouth. There was positive interaction between the member of staff and the person. The person took their medicine and the member of staff thanked them and ensured that they were given a fresh drink, of their choice, to replace the one that they had used to take their medicine. A relative confirmed that their loved one received their medicine appropriately. They told us "My relative has only been here a short while and staff have been very good at looking at their medication and getting it sorted out."

Medicine records showed that each person had a medicine administration record (MAR) sheet which contained information on their medicines as well as any known allergies. These confirmed that medicines were administered appropriately and on time. Audits were also completed to ensure people received their medicines. However, some of the MAR charts contained handwritten entries. The Nursing and Midwifery Council (NMC) Standards for Medicines Management state that when MAR charts are handwritten that they must be checked by another competent health professional. Records did not show that another competent health professional had checked or signed to confirm that they had checked that the prescribed instructions had been written correctly. One person, who was diabetic, had experienced hypoglycaemia (low blood sugar that occurs when blood glucose drops below normal levels). The provider had not ensured that there were sufficient stocks of the person's prescribed medication. (That is administered to increase their blood sugar when experiencing episodes of hypoglycaemia). The person did not have the medicine that they needed to increase their blood glucose levels to a suitable level. The provider had taken prompt action and had contacted the emergency services for advice, the person had been provided with an alternative source of glucose and their blood glucose levels had stabilised.

Most medicines were stored correctly. Extreme temperatures (hot or cold) or excessive moisture causes deterioration of medicines. Records showed that the medicine room and the medicine's fridge temperatures had not been checked on six occasions. Observations of the medicine's fridge temperature showed that it was not within the recommended limits. However, when this was raised with staff this was immediately reported to the maintenance team. The medicine fridge was not clean. Two bottles of nutritional supplements were sticky and had soiled labels, making them illegible. This meant that it was impossible to reliably identify the person for whom the supplement had been prescribed.

Medicines can be less effective or harmful if they are out of date. Some liquid medicines have a limited shelf life once they are opened. Observations showed that the date of opening had not been recorded on some of these medicines and some had not been disposed of once they had expired. For example, one medicine had a shelf life of three months once it had been opened. This bottle was not marked with the date of opening. MAR charts showed that it had been opened for seven months. Another medicine had a shelf life of twenty-eight days once it had been opened. This medicine had been marked as opened two months previously. This meant that people may have been given out of date medicine as there was no system to check that medicines were still in date. This was immediately raised with a member of staff. The expired medicines, as well as the medicines that had illegible labels on, were immediately removed and disposed of.

The provider had implemented a new procedure for the administration of topical creams. The administration of topical creams was undertaken by care staff. However, staff dispensing the medicines signed to state the creams had been administered on the MAR charts. Care staff felt that this procedure was not effective and our observations confirmed this. There were gaps of signatures on MAR charts and where the prescription was to apply creams, 'as needed' it was difficult to understand whether the gaps in the MAR chart indicated that creams had not been administered or if they were not administered because they were not required.

Some people were supported to have their medicines covertly. People who may not be able to make decisions about their treatment and care may need to be given their medicines without them knowing, for example hidden in their food or drink. The National Institute for Health and Care Excellence (NICE) guidance for managing medicines in care homes states that a best interest meeting should take place involving the prescriber, pharmacist, family member or advocate to discuss and agree if this is the best option. The person's GP should review their medicines as well as the pharmacist who should then advise the provider of how to administer covert medicines safely. If agreed, a management plan should be made which should contain information on these reviews, the decision taken at the best interest meeting and a date to review the need for continued covert administration of medicines. There was a covert medication policy. One person lacked capacity and their medicines were to be given covertly. The management plan indicated that the GP, pharmacist and a family member had been consulted but there was no record of the meeting or any documented guidance on how the medicine should be covertly administered in a safe way to avoid altering the structure of the medicines.

The provider did not have robust, safe processes for the safe management of medicines and had not ensured that there were sufficient stocks of medicine to ensure that people had access to medicine when needed. This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were cared for by staff that the provider had deemed safe to work with them. Prior to their employment commencing staff's suitability to work in the health and social care sector had been checked. Identity and security checks had been completed and their employment history gained. Documentation confirmed that nurses had current registrations with the Nursing and Midwifery Council (NMC).

There were sufficient staff to ensure that people were safe and cared for. A dependency tool was used to inform the baseline for staffing levels. Consideration of people's needs and abilities was taken into account as well as feedback gained from staff in relation to staffing levels. For example, staff had provided feedback regarding the staffing levels not being adequate, during peak periods, for people living in the upstairs part of the home. The provider had listened to this feedback and additional staffing was implemented. Staffing levels were increased dependent on people's changing needs and abilities. For example, when people were at the end of their life and required a member of staff to stay with them. When people required assistance

staff responded in a timely manner. Call bells and requests for help were responded to promptly. One person, who had recently had a fall, confirmed this. They told us "I screamed and they came quickly." Another person told us that staff responded quickly enough when they required assistance.

Staff had an understanding of safeguarding adults, they had undertaken relevant training and could identify different types of abuse and knew what to do if they witnessed any incidents. There were whistleblowing and safeguarding adults at risk policies and procedures. These were accessible to staff and they were aware of how to raise concerns regarding people's safety and well-being. (A whistleblowing policy enables staff to raises concerns about a wrongdoing in their workplace.)

Suitable measures had been taken to ensure that people were safe, but their freedom was not restricted. People were supported to undertake positive risks, we observed people, who had been assessed as being at risk of falling, walking independently around the home using their mobility aids. Risk assessments recognised people's physical and clinical needs as well as environmental hazards and were reviewed regularly. Staff confirmed that they found risk assessments and information within people's care plans useful as it provided them with guidance about how to support people in a safe manner. Observations showed that staff were aware of risk assessments and worked in accordance with them. For example, care records for one person stated that the person needed to be supported by two staff and that a stand-aid hoist should be used. Two members of staff were observed assisting the person to transfer from their armchair to a wheelchair using the recommended hoist.

Accidents and incidents were recorded and action had been taken to reduce the risk of the accident occurring again. For example, risk assessments and care plans had been updated to reflect changes in people's needs or support requirements. One person, who disliked using a hoist, had tried to get out of the hoist sling. As a result they had sustained a minor injury. Risk assessments and guidelines had been reviewed following this and it had been advised that three members of staff support the person so that they could offer reassurance whilst the hoist was being used. Another incident had occurred, where a person had sustained a head injury. As a result of this incident staff had been reminded of the head injury protocols that they needed to adhere to in the event of people sustaining an injury to their head.

People were protected by the prevention and control of infection. Staff had undertaken infection control training and infection control audits were carried out. There were safe systems in place to ensure that the environment was kept hygienically clean. Staff were observed undertaking safe infection control practices, they wore protective clothing and equipment, washed their hands, applied alcohol gel in between each task and disposed of waste in appropriate clinical waste receptacles.

Requires Improvement

Is the service effective?

Our findings

People were cared for by staff that had the relevant experience and skills to meet their needs. One person told us "They're friendly and helpful and know what they're doing." Most observations confirmed staff's competence and ability to support people appropriately. Some staff had worked at the home for a long time and it was evident that this continuity of staff meant that they knew people's needs well. A GP who visited the home regularly told us "The staff know their residents and look after them well." However, despite this we observed a minority of staff not providing the support that people required, particularly in relation to eating and drinking.

People's risk of malnutrition was assessed upon admission, a Malnutrition Universal Screening Tool (MUST) was used to identify people who were at a significant risk and they were weighed each month to ensure that they were not losing any more weight. Records showed that referrals to health professionals had been made for people who were at risk of malnutrition, these included referrals to the GP and dietician. Advice and guidance provided had been followed. For example, the completion of food and fluid charts to monitor people's intake, the need for soft diets and the fortifying of foods. Observations showed that the advice given had been followed and people were supported to have food and drink that was prepared according to their needs and in sufficient quantities. There was a bowl of snacks and a drinks dispenser in the communal area to enable people to help themselves. Observations showed that people were offered snacks throughout the day. One relative told us "My relative, in a short time, has put weight on since being here." One person, who liked to spend their time walking, and therefore did not sit down for meals, was supported by staff to take snacks and foods that they could pick up and eat whilst they were walking.

Most people received appropriate support to eat and drink. However, for a minority of people, they were not supported in such a way that was conducive to creating a sociable and positive dining experience. The home had a first and second floor. Although people living on each of the floors did not have vastly different care needs, the experience of care that they received, in relation to support with eating and drinking, was very different.

People on the first floor had a positive dining experience. People were given choice as to where they ate their meals. Some people chose to eat their meals in their rooms, whilst others chose to go to the main dining room or lounge. The dining room was a pleasant environment and people had a positive experience. Tables were laid with tablecloths, placemats and condiments. One person was asked by a member of staff "What can I get you to eat?" People were able to choose what they had for their meals, they were asked the previous day what they wanted to eat and there was a written menu and photographs displayed in the dining room to inform people of the menu available. For people who required assistance with eating and drinking, observations showed that they had a positive dining experience. They were supported by staff that appeared to know their needs and preferences well. One member of staff was overheard asking a person if they wanted to eat their soup. They explained what the soup was and asked if they could offer the person any assistance. The member of staff supported the person to eat the meal at their own pace, interacting with them throughout. Another member of staff was observed supporting someone who appeared to be showing signs of anxiety. The member of staff began to sing a song to the person, this made the person feel

at ease and they ate their meal. Another person indicated that they wanted to dip their bread into their soup. The member of staff offered support to the person and explained that they could eat it any way they liked. The person was then observed dipping their bread into their soup and enjoying their meal. However, not all people had a positive dining experience.

People living on the second floor of the home had a poor dining experience. They did not receive appropriate support to enable them to have a positive experience that was conducive to maintaining good nutrition and hydration. There was a dining room on the second floor. However, people were not supported to go to the dining room to eat their meals. The Alzheimer's Society suggests making the environment as stimulating to the senses as possible to encourage people living with dementia to eat and drink. For example, familiar sounds and smells of cooking and tables laid ready for a meal. There was no preparation of the room before lunch to support people's orientation of meal times. Observations showed people were supported to have their meals, using small lap tables, in the chairs that they had been sitting in, which did not aid a good posture for eating and digestion. The tables were not laid with utensils, napkins or condiments and observations showed that people didn't appear to be offered any condiments to flavour or season their meal. Instead, staff held the plates for people and assisted them to eat their meal. There was no explanation from staff as to what the meal was. However, one member of staff was observed saying "Here are some carrots." There was limited communication with people. Staff did not interact or engage in conversation with people to make the meal time a positive or social experience.

Most of the people needed assistance to eat their meal. This meant that staff had to support one person and then move on to support the next. Observations showed that the meals were not kept warm, this meant that people who had to wait to have support were provided with a cold meal. People were not supported to have their pudding until all of the people had eaten their main meal, this meant that people were sometimes waiting up to forty minutes for their pudding. Feedback regarding this experience, was provided to the management team. This was immediately addressed with the staff that had offered the support and the provider reviewed the dining experience for people living on the second floor. This is an area in need of improvement.

Staff had undertaken an effective induction programme. During induction staff undertook essential training to ensure that they had the relevant knowledge to carry out their duties. As part of the induction process staff were encouraged to shadow more experienced members of staff. One relative confirmed this, they told us "You notice when the new ones start, they always work alongside the older, experienced staff and you can see them learning the job. You can tell they are getting training." One member of staff we spoke to told us that the induction had been really helpful to them. They told us "I felt competent after my induction, all aspects of people's care and needs were covered."

The provider was aware of the importance of staff retaining and developing their skills and knowledge. Registered nurses and care staff completed training on how to support people living with dementia as part of the essential training and had access to other on-line training to meet people's specialist needs and conditions. Registered nurses were registered with the Nursing and Midwifery Council (NMC) and updated their knowledge and competence through regular training. Staff felt adequately supported. They explained that the management team were approachable and supportive and were available if they needed any advice or guidance. Formal supervisions took place and provided staff with the opportunity to reflect on their practice, identify learning and development needs and receive feedback. Staff told us that they found the supervisions helpful as they provided them with a dedicated time to look at their practice and development.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of

people who may lack the mental capacity to do so for themselves. The 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. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the provider was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. The manager had undertaken mental capacity assessments for some people, was aware of DoLS and had made the necessary applications. Observations showed that consent was gained before staff supported people.

People's health needs were met. People received support from healthcare professionals when required, these included GPs, chiropodists, opticians and dentists. There was a weekly visit from a GP. For people with more complex conditions the provider had made the necessary referrals to ensure that people received the support they needed. This related to one person who had impaired vision, referrals had been made to a Rehabilitation Officer for Visual Impairment (ROVI). Another person, who due to a decline in their cognitive abilities, was becoming anxious and distressed when being supported with their personal care needs. This person was referred to the Living Well With Dementia Team. (LWWD). People confirmed that they had access to health care professionals. One person told us "The dentist visits every so often and chiropody is every few weeks." Relatives also confirmed that people received support from external health professionals. One relative told us "My relative had a chest infection about a week ago and they got the doctor and rang me to let me know. The communication is very good."

Good

Is the service caring?

Our findings

People were supported by staff that were kind and caring. There was a caring, friendly and relaxed atmosphere within the home. Staff appeared to know people well and it was apparent from people's reaction that they enjoyed the interaction with staff. People and relatives confirmed this. One person told us "They're brilliant, so helpful, I can't fault it." A relative told us "My loved one has only been here a few days but is happier than before." A GP who visited the home each week told us "Yes, they are caring. Every time I attend the home I am impressed with how the staff treat the residents, they are caring and supportive to them."

Staff communicated with people using their preferred name and adapted their approach to meet people's needs and preferences. The Alzheimer's Society advises that time should be taken to listen to people's feelings and that patience and understanding should be shown when supporting people who are experiencing signs of distress or anxiety. Observations confirmed that staff were mindful of this. One person, who was being supported to have a drink by a member of staff, was showing signs of apparent anxiety. The member of staff recognised this and began to sing a song with the person. This immediately reassured the person and the person appeared to calm down and drink their drink. Another person, who was showing signs of being cross and anxious, was shouting "No" when staff were attempting to approach them. Observations showed staff supporting this person with sensitivity and respect to maintain their dignity. They adapted the way they communicated with the person to ensure that they were provided with the space they needed. When the person was a little calmer, staff approached the person and sat beside them, maintaining eye contact and asking them if there was anything they could do to help. The person responded well to this interaction and it was clear that staff knew the best way to support this person during times of distress or anxiety.

People were supported equally and their differences were respected. They were supported by staff that had a cheerful and approachable nature. They created a fun and warm atmosphere whilst being sensitive to people's feelings and needs. One relative confirmed this, they told us "They share a joke with my loved one and make them laugh. They're so patient and you never see them rushing anyone." Observations showed staff enjoying games with people, singing songs and talking with them about their family and interests. People appeared happy and at ease with the support provided by staff. Staff were overheard communicating with people and showed genuine care and warmth, commenting "Hello (name), how are you today, it's lovely to see you." Whilst another member of staff was heard telling someone how nice they looked as their hair looked lovely. Relatives recognised the importance of staff communicating with people. One relative told us "I like the fact that they talk to my loved one as though they can actually talk back."

Staff were mindful of people's right to privacy and personal space. Observations showed some staff placing an arm around a person or holding their hand when communicating with them. People appeared comfortable with this approach and it was clear staff adapted this to suit people's preferences and needs. People were asked for their permission before being supported with any task. Staff knocked on people's doors and waited for a reply before entering. Privacy was maintained when assisting people with their personal care. Staff supported people in a discreet and sensitive manner, ensuring that doors were closed to

maintain people's privacy and dignity. People's right to confidentiality was respected. Records held about them were stored in locked cabinets and offices to ensure that their privacy was maintained.

People were encouraged to maintain relationships with one another as well as family and friends. Within the guide provided to people when they first moved into the home, people were informed that there were no set visiting hours. It stated that 'You can choose to entertain your family and friends in your room or in one of our communal areas. Family and friends are welcome to stay for meals and you can celebrate family occasions such as Birthdays and Anniversaries.' A room had been adapted to enable relatives and visitors to make themselves drinks. Observations showed visitors and relatives helping themselves to these and sharing refreshments with their loved ones. There were quiet spaces where people were able to meet with their relatives and visitors so as to maintain privacy. The provider recognised the importance of people maintaining contact with their relatives, even when they lived far away. Observations showed one person using technology to 'Skype' their relative who lived oversees. (Skype is a technology system that enables people to have conversations or share video messages with one another over the internet.) Relatives told us that they were made to feel welcome. One relative told us "I'm always made to feel welcome and you can come anytime."

People were supported to be independent. Observations showed people independently walking around the home and expressing their views to ensure they were involved in making decisions about how they spent their time and how they were supported. The provider had accessed additional support for people who required assistance to maintain their independence. The Alzheimer's Society state that 'Advocacy services for people with dementia will help people living with dementia when making key decisions in their lives and will empower and support them to make the right choices for them.' The provider had recognised this and one person had access to an Advocate to support them to make decisions about their care and treatment.

People were able to stay at the home until the end of their life. People were asked their preferences in relation to their end of life care, a meeting was held between the person's GP, the person and their relative to discuss the person's end of life care wishes. Records showed that people's end of life care had been discussed and advance care plans devised. Staff had received training on end of life care and there were links with local hospices that provided practical support and advice to ensure that people received appropriate end of life care.

Good

Is the service responsive?

Our findings

People were treated as individuals. They were supported according to their needs and preferences and were able to choose how they spent their time, observations confirmed this. However, some relatives and staff felt that people needed to be provided with more time to enable their social needs to be sufficiently met.

Relatives and staff felt that staffing levels did not allow adequate time for people's social needs to be addressed. For example, one member of staff told us that there was enough staff to meet people's physical needs but not enough to enable staff to spend time with them. Another member of staff confirmed this, they told us "We need more staff to provide more one to one time with people. We do our best and interact with them as much as we can but staffing levels need to improve." A relative told us "They really need more staff, they don't have enough time to chat to people and it's very hard for them as there are so many that are completely dependent on them." However, people were happy with the amount of support provided and observations confirmed that staff spent time with people to ensure that their social needs were met.

The Alzheimer's Society state that spending time in meaningful activities can continue to be enjoyable and stimulating for people living with dementia and that taking part in activities based on the interests and abilities of the person can significantly increase their well-being and quality of life. The provider had taken this into consideration. People were supported to take part in a range of activities. Observations showed people taking part in group activities such as hoops and balloon tennis and people appeared to enjoy these activities, smiling and showing enjoyment. People were supported to listen to music and clearly enjoyed this, singing along with the songs and tapping their hands and feet. One person, who was spending time on their own, was supported to play a game of cards, the game was adapted to meet the person's level of understanding and enable them to take part. Staff told us that they used information from people's care plans as well as information gained from talking to people to understand what people liked to do with their time and what they enjoyed. One member of staff told us about a person who used to like to take pride in cleaning their home. Staff had supported the person to undertake some light dusting. The person told us that they liked to help with the cleaning. Another person, who used to travel extensively with their work and who enjoyed cars, enjoyed looking at photographs of cars and doing jigsaw puzzles with photographs of cars on. Observations showed another person, who liked to spend time outside, being supported by a member of staff to walk in the garden.

Records further confirmed people's involvement in activities. Records showed that various other activities were offered to people. These included arts and crafts, move 'n' groove, quizzes, games, flower arranging, outings, garden parties and visits from external entertainers. There were plans for a Harpist to entertain people on Mother's day. One person was a fan of Elvis Presley. An Elvis Presley entertainer had provided entertainment to people and one member of staff told us how much people enjoyed this. They told us "It was lovely to see, people really came to life, and they clearly enjoyed it." Photographs of people with the entertainer showed them enjoying the music and interaction. One relative confirmed that people really enjoyed the entertainment that was offered. They told us "I'm a concert pianist and me and a member of staff, who has a lovely voice, do a little concert, they love it. I think entertainment is better than activity, it's true entertainment that they really need."

People who chose to spend time in their room were supported by staff. Staff took time to talk and listen to people's needs and ensure that people were not at risk of social isolation. Records showed that people had been given the opportunity to take part in activities and when they had chosen not to were supported to take part in more one to one activities such as reading, talking or listening to music.

People were given a guide to Oakhill House when they first moved into the home. This informed people of what they had a right to expect and provided them with information in relation to care reviews. The guide stated 'We want you, your family and others who care about you, to have a say in all of the decisions made about your care and support. That's why we will conduct regular reviews with you, and we'll involve your family in planned meetings.' This had happened. People and their relatives were involved in devising and reviewing care plans to ensure that their needs were met. People's needs had been assessed when they first moved into the home. There were comprehensive, person-centred care plans in place detailing people's medical, physical, cognitive and social needs. (Person-centred means putting the person at the centre of the planning for their lives.) The provider was in the process of implementing a new care plan system. Records showed that people and their relatives had been asked to contribute to the reviewing of care needs and the devising of the new care plans and that their preferences were respected. One relative told us "We did a care plan together at the beginning and I've had a letter to come in and go through it with them, but it's my fault as I've not sorted out a time with them, but they have tried." Staff were aware of the changes in people's needs and information had been shared amongst the staff team at handover meetings.

People were supported to make choices in their everyday life. Observations showed staff respecting people's wishes in regards to what time they wanted to get up, what clothes they wanted to wear, what activities they wanted to do, what they had to eat and drink and what they needed support with. People were happy with their rooms and were able to personalise these with their possessions. Observations showed that people's rooms had been furnished according to their preferences and individuality and they were able to display their own ornaments and photographs. Feedback from people confirmed this. Records of a recent resident survey showed that one person had commented 'No problem having my own things in my room.'

People's skin integrity and their risk of developing pressure ulcers were assessed using a Waterlow Scoring Tool, this took into consideration the person's build, their weight, skin type and areas of risk, age, continence and mobility. This assessment was used to identify which people were at risk of developing pressure ulcers. For people who had pressure ulcers, wound assessment charts had been completed providing details of the wound and the treatment plan recommended. Photographs of wounds had been taken to monitor their improvement or deterioration and these were regularly reviewed. There were mechanisms in place to ensure that people at risk of developing pressure ulcers had appropriate equipment to relieve pressure to their skin, these included specialist cushions and air mattresses. People had been assessed to determine the type of cushion and mattress that was appropriate as well as the setting that the mattress was required to be on. Records showed that checks to ensure that settings for mattresses were correct had been carried out and were further confirmed by our observations.

Observations of other people being supported showed that their care and support was personalised to meet their needs. For example, there was a section within people's care plans titled 'Map of life,' this contained information about the person's life, their past employment, interests and hobbies. One person's 'Map of life' care plan contained information about the person's previous job as a Matron. One member of staff told us that this person used to enjoy 'managing' the care staff within the home, however since their cognitive ability had deteriorated they no longer did this. However, despite this change, observations showed that staff continued to respect this person's preferences. Staff were observed speaking to the person and calling them 'Matron'. Despite the person having limited verbal communication, it was apparent, due to their facial

expressions and smiles, that they responded well to this interaction.

Another person's care plan contained information about their support needs in relation to their cognitive needs and anxiety levels. This person disliked receiving support with their personal care needs. The care plan contained detailed information informing staff of how best to support the person so as to reduce their anxiety. It advised that there should be three members of staff offering support to the person. Two of which would provide support to the person to manage their personal care needs and one who would offer reassurance and comfort. Observations showed staff implementing this. Staff held the person's hand and communicated with them, engaging in conversations to distract them from the support being provided. This appeared to calm the person and their anxiety was minimised. The person was later supported to the dining area and appeared calm and happy.

The Alzheimer's Society state that some people living with dementia often have difficulty moving around the home. That changes to the home can help people cope better with the difficulties they experience and maintain their independence. The provider was mindful of this. There was clear signage on doors informing people of the bathroom facilities. Each person's bedroom door had a memory box with photographs or items in it that were important to them, to further assist their orientation and enable them to know which was their bedroom.

There was a complaints policy in place, this was clearly displayed on the notice board and people were informed of their right to make a comment or complaint, in the guide that was provided to them when they first moved into the home. Complaints that had been made had been dealt with promptly and in line with the provider's policy. The provider encouraged feedback from people and their relatives, there was a 'suggestions and compliments leaflet' that could be completed and people were asked for their feedback through regular surveys. Results of a relatives survey showed that one relative had commented 'Care has been excellent, no complaints at all.' People confirmed this, one person had completed a resident survey and had commented 'If I would like to discuss things, then I would be able to.' Whilst another person commented 'I have no complaints.'

Good

Is the service well-led?

Our findings

People and relatives felt that the home was well-led. One relative told us "A neighbour recommended the home and when we came to visit, the manager was lovely, and so our first impressions have continued."

The home had been without a registered manager for six months. There was an acting manager and a head of care, who were both trained nurses, responsible for the day to day management of the home and people's care. The management team had a visible presence in the home and it was apparent that they knew people's needs and preferences well. Observations showed them interacting and communicating with people. They provided positive role models for staff. Staff told us that they felt that the home was managed well and they were supported within their roles. One relative told us "It's much better now with the new management, you feel that they'll actually sort things out now if you speak to them. I feel much happier about the place." The home had a staff team that had worked at the home for many years. Staff told us that they were happy in their roles and enjoyed their work. A GP, who visited the home regularly, told us "The manager has been at the nursing home for some time and knows the residents well and is supported by excellent nurses. They have a number of carers who have been in post for some time whom support the management team well. A home which has a strong and stable leadership will always do well."

The provider had a philosophy of care. This stated that people had a right to privacy, dignity, choice, independence, individuality and diversity. Observations confirmed that this philosophy was embedded in the culture and practice of staff. It was evident that the service was provided to meet the needs of people and that there were mechanisms in place for partnership working, enabling people and their relatives to be involved in their care. Feedback that had been gained had been used to enhance practice and drive improvement. For example, in one relative's meeting it had been discussed about the need to encourage independence. It had been suggested that a washing machine and a cooker be purchased for the activities room so that people could enjoy cooking and undertaking domestic tasks. Staff confirmed that this was in the process of being implemented. One professional told us "I was particularly impressed with the provider's transparency with residents, opportunities for resident feedback via a number of channels such as internal procedures, residents meetings and external sources such as health watch are in place."

It was apparent that the management team were aware of the importance of questioning practice and addressing issues of practice that didn't comply with the provider's philosophy of care. Observations of a minority of staff, supporting people with eating and drinking, in a way that was not consistent with this, was fedback to the management team at the end of our inspection. The management team were receptive to this feedback and immediately held supervision meetings with the members of staff to address the concerns and provide additional support to remind them of the importance of professional conduct and treating people in accordance with the philosophy of care.

The provider ensured that links with the local community were maintained. People were provided with entertainment from external entertainers and were supported on outings. There were plans to support people to visit the beach in the warmer weather to enjoy a meal of fish and chips. There were links with external organisations to ensure that the staff were providing the most effective and appropriate care for

people and that staff were able to learn from other sources of expertise. These included links with the local authority and local hospices. One member of staff told us that the manager was arranging for them to visit other homes within the organisation so that best practice was observed and shared.

The provider was aware of their responsibility to comply with the CQC registration requirements. They had notified us of certain events that had occurred within the home so that we could have an awareness and oversight of these to ensure that appropriate actions had been taken.

There were rigorous quality assurance processes. Regular audits took place to enable the manager to have oversight of the processes in place to identify what was working well, or if there were any trends or areas of improvement required. Annual quality assurance surveys were sent to people, their relatives and staff to gain their feedback, these were analysed by the provider and used to drive change. Quality audits were reviewed and discussed at regular meetings with the area manager, who also made regular visits to the home to monitor the quality of care provided.

The manager had reviewed and changed practice, as a result of the audits undertaken, to ensure that they were working in accordance with best practice guidance, changes in legislation and regulations. For example, there was a 'falls analysis' audit undertaken. This monitored the amount of falls, and the location and time that they had taken place. This information had been used to identify patterns and trends. Action resulting from this audit, showed that equipment had been purchased for staff to monitor people's actions. For example, using sensor mats. It was also identified that a number of falls occurred at a certain time of the day. In response to this it had been suggested that there be more activities and staff interaction with people to engage them and prevent them from becoming restless and therefore at more of a risk of falling.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2014 Safe care and treatment. Regulation 12 (1) (2) (f) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Safe care and treatment The registered person had not taken the appropriate action to ensure the proper and safe management of medicines or to ensure that there were sufficient quantities of these to ensure the safety of service users to meet their needs.