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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	Good

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

Summary of findings

Overall summary

This inspection took place on 5 and 16 January 2018. The first day of our visit was unannounced and the second day was planned and agreed with the management team.

Oak House is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. The Care Quality Commission (CQC) regulates both the premises and the care provided, and both were looked at during this inspection. The home is a grade two listed building situated in the town of Axminster. The service is registered to provide care and accommodation for up to 17 people. They provide care and support for frail older people and some living with dementia. There were 17 people living at the service when we visited.

At the last inspection in November 2016, we found a breach of regulation of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the provider had not ensured that people were always treated with dignity and respect and their privacy was not always maintained. The service had been rated as requiring improvement overall. Following the inspection the provider sent us an action plan telling us the improvements they would make. This included staff receiving supervision to discuss concerns and putting in place curtain screens in shared bedrooms. At this inspection we checked to see whether the requirement had been met and found it had been addressed.

The registered provider is also the registered manager of the service. A registered manager is a person who has registered with 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 manager had delegated the day to day running of the service to a new acting manager who had started working at the service in November 2017. The provider's area manager worked at the home at least one day a week to provide support for the management team.

People, visitors and staff gave positive feedback about the management team. They were happy to approach them if they had a concern and were confident that actions would be taken if required. The management team and staff promoted person-centred care and a family-like atmosphere at the service. People were treated equally with any diverse requirements accepted and met.

There were sufficient numbers of suitable staff to keep people safe and meet their needs. People were supported by staff who had the required recruitment checks in place and were trained and had the skills and knowledge to meet their needs. Staff had received a full induction and were knowledgeable about the signs of abuse and how to report concerns.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice. The staff demonstrated an understanding of their responsibilities in relation to the Mental Capacity Act (2005) (MCA).

Where people lacked capacity, mental capacity assessments were completed and best interest decisions made in line with the MCA.

The CQC monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. DoLS provide legal protection for those vulnerable people who are, or may become, deprived of their liberty. The service had made appropriate applications to the local authority DoLS team for people they had assessed as needing to be deprived of their liberty.

Staff were friendly in their approach and maintained people's privacy and dignity while undertaking tasks. They supported people to maintain a balanced diet and knew people's likes and dislikes and ensured people had their preferred meal choice. We observed two lunchtime meals where people were seen being supported discreetly and enjoying their meals.

People received their prescribed medicines on time and in a safe way. Improvements had been made regarding the applications of prescribed creams and people received these as prescribed.

People were supported to undertake activities. There was a new activity co-ordinator who was implementing a range of activities to suit different people's personal interests. The co-ordinator confirmed people who could not take part in the group activities had one to one time allocated.

Risk assessments were undertaken for people to ensure their health needs were identified. Care plans reflected people's needs and gave staff clear guidance about how to support them safely. Care plans were person-centred and people, where able, and their families had been involved in their development. The new acting manager had plans to improve people's mental health care plans, to include further information about behavioural triggers and de-escalation techniques when people become agitated or distressed. People, where able, were involved in making decisions and planning their own care on a day to day basis. People were referred promptly to health care services when required and received on-going healthcare support.

The premises were well managed to keep people safe. There were individual emergency plans in place to protect people in the event of a fire or emergency.

The provider had a robust quality monitoring system at the service. The provider actively sought the views of people, their relatives and staff through staff and residents meetings, surveys and questionnaires to continuously improve the service. There was a complaints procedure in place. There had been two complaints since our last inspection, which had been responded to in line with the provider's complaints policy.

Further information is in the detailed findings below.

Please note that the summary section will be used to populate the CQC website. Providers will be asked to share this section with the people who use their service and the staff that work there.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

People said they felt safe and staff had a good understanding of what constituted abuse and how to report if concerns were raised.

There were sufficient staff on duty to meet people's needs.

There were effective recruitment and selection processes in place.

People's medicines were safely managed.

There were effective infection control processes in place.

The premises were well managed to keep people safe.

Is the service effective?

Good

The service was effective.

Staff understood their responsibilities in relation to the Mental Capacity Act (MCA) (2005) and Deprivation of Liberty Safeguards (DoLS).

Staff received training and supervision which enabled them to feel confident in meeting people's needs and recognising changes in people's health.

People's health needs were managed well and they saw health and social care professionals when they needed to and staff followed their advice.

People were supported to maintain a balanced diet.

Is the service caring?

Good

The service was caring.

People and relatives gave positive feedback about the caring nature of the staff. They said staff treated them as individuals

and with dignity and respect.

Staff knew the people they supported, their personal histories and daily preferences.

Staff were friendly in their approach and maintained people's privacy and dignity while undertaking tasks.

Visitors were encouraged and always given a warm welcome.

Is the service responsive?

Good

The service was responsive to people's needs.

Staff knew people well, understood their needs well and cared for them as individuals.

People's care plans were personalised and guided staff how to meet their needs. Their care needs were regularly reviewed and assessed.

Action was planned to improve care plans regarding people's mental health needs to guide staff about triggers and actions to take.

People knew how to raise a concern or complaint. The management team were aware of their responsibilities in relation to dealing with complaints.

People were supported to take part in social activities. Improvements had been put in place to increase the activity provision at the home to ensure people had meaningful activities.

Is the service well-led?

Good

The service was well led.

One of the provider's was also the registered manager; they delegated the day to day running of the service to an acting manager. They were supported by an area manager and a care manager.

Systems were in place to effectively assess, monitor and improve the quality and safety of the service provided, and mitigate any risks.

The staff were well supported by the management team.

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

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.

This inspection took place on 5 January and 16 January 2018 and was unannounced on the first day. The second visit was announced as we wanted to speak with the registered manager who was also a provider and the new acting manager. The inspection team comprised of one adult social care inspector.

Prior to the inspection we reviewed information we held about the service, and notifications we had received. A notification is information about important events, which the service is required by law to send us. We used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least annually to give us some key information about the service, what the service does well and improvements they plan to make.

We met and observed most of the people who lived at the service and received feedback from three people who were able to tell us about their experiences. We also spoke with two visitors to ask for their views on 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.

We spoke with and sought feedback from 10 staff including the acting manager, care manager, deputy manager, care staff, the maintenance person, cook, and activity person. We also spoke with the registered manager who is one of the directors, another director and the area manager.

We reviewed information about people's care and how the service was managed. This 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 health professionals. We sought feedback from the local authority safeguarding team and local authority Quality assurance Team (QAIT) to obtain their views of the service provided to people. We also contacted four health and social care professionals to obtain their views of the service provided to people. We received feedback from two of them.

Good

Is the service safe?

Our findings

At the last inspection in November 2016, people's medicines were being safely managed, with the exception of prescribed topical creams. The provider had taken action and a new system had been implemented. At this inspection there were safe medication administration systems in place and people received their medicines when required. Prescribed creams were recorded on people's medicine administration records (MAR). The information had been transferred onto cream administering sheets held in people's rooms; these sheets were signed by care staff when they administered topical creams. A new checklist was completed by senior care staff each day which included checking the cream charts to ensure staff had applied creams as prescribed.

Improvements were also needed at the last inspection to ensure there were safe and effective recruitment processes in place. At this inspection the service followed safe recruitment practices. Staff files included application forms, records of interview and appropriate references. Records showed that checks had been made with the Disclosure and Barring Service (criminal records check) to make sure people were suitable to work with vulnerable adults. Staff were not allowed to start work until satisfactory checks and employment references had been obtained. The provider had recorded in the provider information return (PIR), "Staff are thoroughly checked before employed, and their empathy is as important as documented qualifications, the nature of the job requires individuals to support others in what is sometimes difficult situations."

People felt safe living at the home and with the staff who supported them. One person said, "Oh yes I am safe." Not everyone was able to fully express themselves due to their dementia. Everyone looked very comfortable and relaxed with the staff who supported them. A health professional said, "Generally there is a good level of safety. We have not identified an unexpected number of injuries, falls or poor care at Oak House." Staff had received training on how to recognise and report any suspicions of abuse. Staff understood the different types of abuse and said they were confident that if they raised concerns, action would be taken to make sure people were safe.

Staff had a good understanding of how to keep people safe and their responsibilities for reporting accidents, incidents or concerns. They completed accident records accurately with the information required and the actions they had taken. These were reviewed by the management team to ensure good practice had been followed.

People received their medicines safely and as required. People's medicines were administered by senior care staff who had been trained and had their competency assessed to administer medicines. The management team had been working with the local community nurse team so staff were trained and assessed to administer insulin to a specific person at the service.

Staff were seen administering medicines in a safe way. They asked people if they required any pain relief and always ensured people had a drink and stayed with them until they had taken their medicines.

There was a system in place to monitor the receipt and disposal of people's medicines. There was a

procedure to monitor daily the temperature of the medicine fridge and the medicine trolleys where medicines were stored. Medicines at the service were locked away in accordance with the relevant legislation. Medicine administration records were accurately completed. The pharmacy that supports the service had completed a review in October 2017 and raised no significant concerns. They had recommended that the provider had a more up to date medicine formulary directory which had been purchased.

Where people had medicines prescribed as needed, (known as PRN), there were protocols in place for when and how they should be used, which is good practice. For example for using a rescue medicine for someone with an allergy and when somebody has a low blood sugar and requires a glucose medicine which could be quickly absorbed. Where a person had a swallowing difficulty, staff had worked with the GP and pharmacist about having liquid medicines and whether tablets could be crushed. A care plan had been put in place to guide staff about how they supported the person with their medicines.

People were protected because risks for each person were identified. Risk assessments about each person were undertaken which identified measures taken to reduce risks as much as possible. These included risk assessments for falls, skin integrity and nutrition.

People were supported by sufficient staff with the right skills and knowledge to meet their individual needs. There was a calm atmosphere at the service during our visits. Staff were seen to be busy but with the time to meet people's needs. People and staff confirmed they felt there were enough staff to meet people's needs. Comments included, "I have a call bell; they answer it quickly" and "Four staff in the morning is adequate for what we need. We have less sickness, now we have more reliable staff."

People's individual equality and diversity was respected. Staff had a good understanding of people's diversity and people had care plans which ensured staff knew how they wanted to be supported. Care plan contained people's personal history, enabling staff to support people in the way they wanted to be, which was seen to be observed in practice.

The environment was safe and secure for people who used the service and staff. One of the providers supported by a designated maintenance person oversaw the maintenance at the service. The maintenance person undertook checks which included regular checks of the water temperature and window restrictors. External contractors undertook regular servicing and testing of moving and handling equipment, electrical and lift maintenance. Fire risk assessments and general risk assessments and the monitoring of environment had been undertaken.

People were kept safe from the risk of emergencies in the home. There were personal emergency evacuation plans (PEEP's) in place to keep people safe in an emergency and staff understood these and knew where to access the information. Fire checks and drills were carried out and there was regular testing of fire and electrical equipment. There were keypads on external doors around the building which had their codes regularly changed. We were present during a fire test, all staff attended as required. After the fire test the testers checked fire doors and exits to ensure they had closed appropriately and were not blocked. Legionella precautions were in place. Staff were able to record repairs and faulty equipment in a maintenance log and these were dealt with and signed off by the maintenance person.

The home was very clean throughout without any odours present and had a pleasant homely atmosphere. The provider's had undertaken some refurbishment since our last visit. This included some new bespoke oak windows, new carpets, redecoration, relocation of the office and the development of a disabled toilet on the ground floor.

Staff had access to appropriate cleaning materials and to personal protective equipment (PPE) such as gloves and aprons. Staff had access to hand washing facilities and used gloves and aprons (PPE) appropriately. The laundry was very small and a little untidy. However soiled laundry was placed in red soluble bags and laundered separately at high temperatures in accordance with the Department of Health guidance. The area manager had ordered some laundry trollies and during the inspection put up signs to remind staff about the importance of keeping the laundry tidy.

Good

Is the service effective?

Our findings

At the last inspection in November 2016 people were not adequately supported to make decisions about their care because staff did not fully understand or follow current legislation. At this inspection improvements had been made and capacity assessments and best interest decision had been made in line with the Mental Capacity Act (2005) (MCA).

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. Where people lacked the mental capacity to make decisions the staff followed the principles of the MCA. Best interest decisions had been made involving relatives, staff and other health and social care professionals as appropriate. For example, regarding nutritional needs such as meat being pureed, the use of bedrails and pressure mats. Staff were able to describe the role of an advocate and were clear if someone did not have family or friends to support them, that an advocacy service could be used. One person had the support from an independent advocate (IMCA) as they had no next of kin.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. We found people who lacked mental capacity to make particular decisions were protected.

The Care Quality Commission (CQC) monitors the operation of DoLS and we found the home was meeting these requirements. The management team were aware of their responsibilities in relation to DoLS and how to make an application if they needed to restrict a person's liberties. None had been assessed or authorised by the DoLS team. People or their legal representatives were involved in care planning and their consent was sought to confirm they agreed with the care and support provided. For example the taking of photographs.

At the last inspection in November 2016 not all staff had received the provider's mandatory training or regular updates to ensure they had the skills to meet people's needs effectively. At that time all care staff with the exception of one had or were working towards a higher qualification in health and social care. At this inspection training provision and oversight by the deputy manager had improved to ensure staff had received the required training.

People received individualised care from staff who had the skills, knowledge and understanding needed to carry out their roles. Staff had completed the provider's mandatory training and ten of the fourteen care staff had a higher health care qualification. People and their relatives spoke positively about staff and told us they were skilled to meet their needs. Comments included: "They are very good", "Nothing is too much

trouble, they know what they are doing" and "I always find the staff to be very professional." One health care professional said, "There has been a better continuity of senior staff at Oak House and this is reflected in better knowledge of the patient, their medication management and level of professionalism."
Staff were positive about the training they had received, "You learn the new ways and new techniques." We received feedback from a health professional who had provided training at the service. They said staff had been engaged and demonstrated a good understanding of the subject.

New staff were supported to complete an induction programme before working on their own. A senior care worker said, "We ensure they understand what they are doing, we work alongside them and teach them and explain about the person and what they need. They usually do three days; if they need longer they can have longer." Staff new to care were supported to complete the 'Care Certificate' programme which had been introduced in April 2015 as national training in best practice.

People were supported by staff who had supervisions (one to one meeting) with the management team. The new acting manager was holding supervisions session with all staff. They said, "This month I am doing supervisions, I am asking staff what they feel could be improved." Staff said supervisions were carried out regularly and enabled them to discuss any training needs or concerns they had. One staff member's supervision records showed how they had received regular meetings and had been supported to improve their practice and to monitor their progress.

The staff were aware of people's dietary needs and preferences. When people came to the service staff asked for likes and dislikes. This information was passed to the kitchen staff. The cook said they had all the information they needed and were aware of people's individual needs. People told us they liked the food and were able to make choices about what they had to eat. One person said, "Food is good most of the time, (cook) does some lovely puddings." We observed two lunchtime meals; staff were respectful and did not rush people. Where people required support this was carried out discreetly and in a respectful manner. Where people required plates guards or specialist beakers these were provided. The acting manager said they had plans to improve the dining experience further which would include speaking with people and discussing introducing background music and new menus.

People's care records showed relevant health and social care professionals were involved with people's care. People were referred appropriately to the dietitian and speech and language therapists if staff had concerns about their wellbeing. People had access to health and social care professionals, including their GPs, dentist and an optician. A health professional said, "We are called promptly when there are medical concerns about patients. Our medical/medication advice is usually followed accurately."
Staff supported people to attend appointments when required. The provider recorded in the provider information return (PIR), "Referrals are made to multi-disciplinary team i.e. SALT (speech and language team), OT (occupational therapist), physio (physiotherapist), chiropodist, optician, dentist, audiology, falls team as required and documented in the care plan."

Staff had supported people to make their bedrooms feel homely. People's bedrooms were personalised with their personal possessions. These included ornaments, photographs, cushions and pieces of furniture. The provider had recorded in their PIR, "All residents and their families are encouraged to personalise their bedrooms with familiar pictures and photos and personal items. Many families come in and do this before their relative joins us so they have some familiar things around them."

Good

Is the service caring?

Our findings

During the last inspection in November 2016 we found a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because people were not always treated with dignity and respect. At this inspection we found the requirements of this regulation were being met.

People and relatives said staff were caring. One person commented, "The staff are alright, They work very hard (staff member) works the hardest. If I send things to the laundry it is sorted." A relative said, "Mum is always well presented…it took a while to settle but seems very happy. Staff keep us informed they are very good."

Staff treated people with kindness and compassion. Throughout our visits staff were smiling and respectful in their manner. They greeted people on their first encounter with affection and people responded positively. The atmosphere at the home was calm and pleasant. We observed, when a care worker came into the main lounge they greeted the person already there. They took the time to get good eye contact and smiled and asked the person how they were and waited for a response. It was clear the person knew the staff member well by the way they reacted and the enormous smile given.

One person's relative had recorded in a thank you card, "To thank you and your staff for making (person) so welcome. At last she is receiving the attention and care which she deserves…has been in four different homes…received reasonable care it has been impersonal. But now at Oak House, she is being treated as a valued guest. All of her needs are being met as far as humanly possible."

People's dignity was respected by staff. Staff were seen to be interacting with people in a calm sensitive manner. For example, one person became muddled several times throughout our visit and kept asking questions. Staff remained calm and answered their questions appropriately and were very patient with the person.
At the service two bedrooms were used for double occupancy which were being used by people who had agreed to use them. The provider had put in place curtains to screen these people when receiving personal care to ensure their privacy and dignity was maintained. They had also ensured these people's data was protected by discreetly storing their care plans inside their wardrobes so were not accessible to visitors or the other person. A health professional said, "Staff appropriately takes patients to a private area to be examined by us and now do this without prompting."
People received care and support from staff who had got to know them well. The relationships between staff and people receiving support demonstrated dignity and respect at all times. For example when one person's clothes were untucked, a staff member took the person to one side and adjusted their clothing discreetly.

Staff knew people's individual communication skills, abilities and preferences. There was a range of ways used to make sure people were able to say how they felt about the caring approach of the service. For example one person had speech impairment, a staff member said, "(Person) is dysphasic (Impairment of speech), some days his speech can be clear, we have found singing makes it clearer." In another's care plan for communication staff had recorded "Can at times have moments where she is able to have a

conversation… staff to talk to (person) and read facial reactions." One person with a sight and hearing impairment had agreed to wear a badge stating they had a hearing and sight impairment. They said staff were supporting them to access talking newspapers.

Staff showed concern for people's wellbeing in a caring and meaningful way, and they responded to their needs quickly. One person became very muddled and kept standing up and getting distressed about what they should be doing. Staff were very patient with this person spending time reassuring them and explaining what was happening.

People's relatives and friends were able to visit without being unnecessarily restricted. Visitors were made to feel welcome when they came to the home. One person said, "My visitors come and go as they please."

Good

Is the service responsive?

Our findings

The service was responsive to people's needs because people's care and support was well planned when their needs changed. Before people came to the service a member of the management team visited them. They discussed their requirements with them to assess if the home could meet their needs. The management team completed a pre-assessment with the person, their relatives and other professionals involved in their care. Care plans were then written using this information to guide staff how the person wanted to be supported. A friend wrote a letter saying, "I am writing to express my gratitude to you all for making what could have been a very traumatic move for (person) to your care home a very positive experience. You have all been kind and compassionate to my friend and for that I thank you. We spoke numerous times about (person's) care and every time I had a query it was always addressed quickly and professionally …It is a comfort to know that I can always talk to a member of staff whenever I need to."

People had care plans that clearly explained how they would like to receive their care, treatment and support. The new acting manager said they planned to further improve care plans regarding people's mental health needs to guide staff about triggers, de-escalation and actions to take if the person became distressed.

We looked at how the provider complied with the Accessible Information Standard. The Accessible Information Standard is a framework put in place from August 2016 making it a legal requirement for all providers to ensure people with a disability or sensory loss can access and understand information they are given. The area manager was aware of the new requirement. They said where people were unable to understand any information staff would discuss it with them and their relative to ensure people were kept informed.

People's needs were reviewed regularly and as required. Where necessary health and social care professionals were involved. An example of this was the involvement of a community psychiatric nurse (CPN) reducing a person's antipsychotic medicines with ongoing monitoring. Staff kept the CPN informed of the progress the person was making and followed the professional's recommendations.

It was very clear each person at the service was being treated as an individual and their diversity recognised. For example one person liked female company and liked to walk arm in arm with a female staff member and banter. Staff were seen with the person they remained respectful and when they arrived at their destination allowed a kiss on the cheek which the person clearly enjoyed. A staff member said they had supported a person in a same sex relationship where they respected the "person's privacy and right to have visits and we respected they could spend quality time together."

In each person's room there was a 'carer's plans' to guide staff about people's main needs. These included information about people's personal care needs, nutritional support required, continence, communication, skin care and activities. The acting manager had put in place new folders in people's bedrooms so they were accessible to staff. In the folder there was a senior care worker checklist, topical cream charts for staff to complete, personal care record tick sheet for staff to record, daily monitoring if staying in their room to

check hourly.

Handover between staff at the start of each shift ensured that important information was shared, acted upon where necessary and recorded to enable people's progress to be monitored. The new acting manager had implemented a new communication book for staff to record changes to people so staff who had been off duty could read and be informed of any changes which had occurred while they were away.

People and their relatives were given support when making decisions about their preferences for end of life care. The providers information return (PIR) said "This is often our resident's last home and we feel we give excellent end of life care to them in the final stage of their life. Family often tell us how supported they felt through this difficult time. When one of our residents is dying, the families are welcome to stay for as long as they wish with their relative and we provide extra support during this time."

There was no one receiving 'end of life' care at the time of our visit. People had Treatment Escalation Plans (TEP) in place that recorded people's wishes regarding resuscitation in the event of a collapse. Where necessary, people and staff were supported by palliative care specialists. A card recently received confirmed the quality of care one person had received. The card read, "How very pleased we were with the high standard of care and compassion shown to my mother during her couple of years with you at Oak House. You and your team have been wonderful, thoughtful and kind throughout and towards the end made her very comfortable. We felt lucky to have found a home for her in such a nice caring environment."

People had a range of activities they could be involved in. The provider had their own minibus to take people out on outings. The area manager said they had taken people to the Sidmouth Pavilion, Sidmouth Folk week and Otter nurseries. A staff member was designated to oversee activities at the home. The current staff member had transferred from the housekeeping team. They were very enthusiastic about the role and said, "I am finding out what they (people) like and what they think. I want to get it right for all of them." They went on to tell us how they had noticed one person became a little unsettled after lunch each day, they had checked the person's profile and that afternoon planned to pair socks and fold towels as this reflected the person's interest. A volunteer also attends the service two days a week to assist with activities and to talk with people. One person said, "We had someone do some painting and making things with clay and we made Christmas cards. A lady comes from the church…we have church services some Sundays and sing hymns." The area manager said they were developing an activity programme and intended to include armchair exercises as well as continue to use external entertainers. A staff member was attending a gardening course, 'Horticulture for dementia' so they could help develop this at the service.

Complaints and concerns were taken seriously and used as an opportunity to improve the service. There had been two complaints since our last inspection which the management team had investigated and responded to in line with their complaints policy. People were confident if they raised a concern with the management team they would take action. One person said, "I can always speak with (care manager) and she will sort it out." Another said "(care manager) is always around."

Good

Is the service well-led?

Our findings

At the last inspection in November 2016 improvements were needed in relation to monitoring the service. An area manager had been appointed to identify where changes and improvements were needed; they were taking action to address these. At this inspection improvements had been made to the quality monitoring at the service. This included regular effective audits. The provider had also had the local authority Quality Assurance and Improvement Team (QAIT) visit the service to help support them put new processes in place. The QAIT officer said the management team had engaged with them well and the systems they had implemented at Oak House had also been implemented in one of the provider's other services.

The provider was the registered manager; they delegated the day to day running of the service to a new acting manager who had started working at the service in November 2017. They were supported at least one day a week by an area manager who was also the registered manager of another service operated by the provider. A deputy manager also worked at the home. The previous acting manager had changed their role and was working as the care manager at Oak House. The registered manager visited the home weekly and met with the management team, staff and people using the service to assure themselves the service was operating safely. They also spoke most days to the area manager to be kept informed about the service. People said they had met the new acting manager, one person said "I think she is nice."

The management team and staff promoted person-centred care and a family like atmosphere at the service where people were treated equally with any diverse requirements accepted and met. Since our last visit the office had been moved to the ground floor so the management team were more visible and accessible to people. The area manager said the reason the office had been moved was so the management had "More of a presence to see what was happening." Throughout our visit people were coming to the desk to speak with the management team. This confirmed what the provider had recorded in their provider information return (PIR), "The home has an open door ethos, where residents and family and friends can speak to the manager or one of the team at any time. The owners of the home are also happy to be contacted if needed."

The staff were well supported by the management team and were positive about the new acting manager. Staff had confidence they would listen to their concerns and would be received openly and dealt with appropriately. Comments included," I think we are heading in the right direction; we have worked very hard to get it where it is. (Acting manager) has some fantastic ideas for the place but is willing to listen", "We are getting better", "(Acting Manager) is very nice, getting things done… made a few changes which makes sense. If I had a concern I feel she would deal with it" and "I think she will do what she says she will do."

The service had a positive culture that was person-centred, open, inclusive and empowering. Staff understood the importance of equality, diversity and human rights. The provider's website stated, "We believe it's extremely important to promote independence and understand that all of our residents should be treated as individuals so each member has a plan of care designed around their requirements and preferences, granting them choice in aspects of their daily routine. We also welcome regular visits from family and friends."

People and those important to them had opportunities to feedback their views about the home and quality of the service they received. Each year people, visitors and health professionals were asked to complete a survey feeding back their views about the service. The area manager said they had recently had responses returned from health professionals which had all been positive. They confirmed the information would be collated and shared with people and with staff at the next staff meeting.

People and visitors were also able to attend 'residents meetings every six months or more regularly if something changed. The provider recorded in the PIR, "Residents and family meetings are held six monthly, choices are documented regarding changes to the menus and menus changed accordingly." The management team produced a monthly newsletter to keep people informed of events and changes at the service.

Quality assurance systems were in place to monitor the quality of service being delivered and the running of the home. These included a managers monthly checklist where the manager undertook checks which included checking people's care plans, staff ratios, general care of people including their appearance, activities undertaken, call bell response times, mealtimes and accurate completion of food and fluid charts. Health and safety checks were also completed; these included bedrail safety which was reviewed monthly. Medicine audits were carried out monthly and actions taken if concerns were identified. First aid boxes were checked monthly to ensure they contained the required equipment and restocked if needed. Other audits carried out included, air mattress checklist, catering audit and accident and incident audits. Policies and procedures were reviewed annually and updated as required and to reflect changes in practice and legislation.

There were accident and incident reporting systems in place at the service. The management team monitored and acted appropriately regarding untoward incidents and looked for trends and themes. They checked the necessary action had been taken following each incident and looked to see if there were any patterns in regards to location or types of incident. Where they identified any concerns they took action to find ways so further incidents could be avoided.

The provider was meeting their legal obligations such as submitting statutory notifications when certain events, such as a death or injury to a person occurred. They notified the CQC as required and provided additional information promptly when requested. The provider had displayed the previous CQC inspection rating in the main entrance of the home and on the provider's website.