Care Quality Commission

Surrey Rest Homes Limited

Oak House Care Home

Inspection report

Oak House
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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**

Overall summary

This was an unannounced inspection which took place on 23 July 2015.

Oak House Care Home is a 16 bedded residential care home that provides care and support to older people living with frailty due to the progression of age or who are living with dementia. At the time of this inspection there were 14 people living at the home.

During our inspection the manager was present. The manager had been in post since April 2015. They had submitted an application to register as a manager with us which was being processed at the time of this inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The manager's application was being processed at the time of this inspection.

Summary of findings

Cleanliness at the home had not been maintained to a safe standard. The manager took prompt action to address this during our inspection. However, we were concerned that this had not been identified by them prior to our intervention.

The manager had not ensured people's human rights were upheld when they lacked capacity to consent. People's representatives had not always been involved in decision making processes when people lacked capacity to consent and DoLS applications had not been made.

People's bedrooms were personalised with possessions such as pictures. However we saw no evidence of anyone's individual or personal interests integrated into the home outside of their rooms. We have made a recommendation regarding this.

People said that they felt safe, free from harm and would speak to staff if they were worried or unhappy about anything. People received care and support that met their individual needs. Risk assessments and care plans were in place that considered potential risks to people. Strategies to minimise these risks were recorded and acted upon. People were safely supported to manage their medicines. People were supported to access healthcare services and to maintain good health.

People who lived at Oak House Care Home, their relatives and staff told us that there were, on the whole enough staff on duty to support people at the times they wanted or needed. Appropriate recruitment checks were completed to ensure staff were safe to support people. Staff were sufficiently skilled and experienced to effectively care and support people to have a good quality of life. People told us that they were happy with the support they received from staff. Staff received training, supervision and appraisal that supported them to undertake their roles and to meet the needs of people.

People said that the food at the home was good. People were offered choices in relation to food and drink and staff assisted people when needed.

Staff were kind and caring and people were treated with respect. Staff were attentive to people and we saw high levels of engagement with them. Staff knew what people could do for themselves and areas where support was needed. We heard staff speaking kindly to people and they were able to explain how they developed positive caring relationships with people.

The manager encouraged staff to work collaboratively so that people received personalised care. The manager was committed to providing a good service that benefited everyone and was aware of most aspects of the service that needed to improve. Plans were in place to address shortfalls.

Quality assurance audits were completed which helped ensure quality standards were maintained and legislation complied with. Accidents and incidents were acted upon and reviewed to prevent or minimise re-occurrence.

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

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was not always safe.

People told us they felt safe. However, we found that cleanliness of the home had not been maintained to safe standards for two people.

Staff understood the importance of protecting people from harm and abuse. Medicines were managed safely. Potential risks were identified and managed that allowed people to make choices and to take control of their lives.

People felt that there were, on the whole enough staff on duty to support them at the times they wanted or needed.

Requires improvement

Is the service effective?
The service was not always effective.

When people did not have the capacity to consent suitable arrangements had not been made to ensure decisions were made in their best interests. Deprivation of Liberty Safeguards (DoLS) applications to deprive people of their liberty had not been made. Therefore people's rights were not protected.

People were cared for by staff who received support to do their jobs. A training programme helped staff to gain the skills and knowledge needed to care for people.

People told us that they were happy with the care and meals provided. People's care needs were managed effectively.

Requires improvement

Is the service caring?
The service was caring.

People were treated with kindness and compassion by dedicated and committed staff.

People were supported to express their views and to be involved in making decisions about their care and support.

People were treated with dignity and respect and their privacy with promoted.

Good

Is the service responsive?
The service was responsive.

People received individualised care that was tailored to their needs. Steps were being taken to expand the range of activities people could participate in so that they had greater access to the wider community.

Good

Summary of findings

People's needs were assessed and care given that reflected changes in people's needs. When recommendations were made by external professionals these were acted upon to ensure people received the care and support they required.

Comments, compliments and complaints were acted upon promptly and people felt that they were listened to.

Is the service well-led?

Good

The service was well- led.

The manager was committed to providing a good service that benefited everyone.

Staff were motivated and there was an open and inclusive culture that empowered people.

People's views were sought and used to drive improvements at the service. Quality assurance systems were in place that helped ensure good standards were maintained.

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 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.

This inspection took place on 23 July 2015 and was unannounced. The inspection team consisted of two inspectors and an expert by experience that had experience of older people and dementia care. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection, we checked the information that we held about the home and the service provider. This included statutory notifications sent to us by the provider about incidents and events that had occurred at the service. A notification is information about important events which the provider is required to tell us about by law. We also reviewed comments that we had received from one health and social care professional who agreed to us using their comments in this report. We used all this information to decide which areas to focus on during our inspection.

We spoke with 10 people who lived at Oak House Care Home and three relatives. We also spoke with three care staff, a chef and the manager who had applied to be registered with us.

We observed care and support being provided in the lounges and dining room. We also joined people for lunch and observed part of the medicines round that was being completed.

We reviewed a range of records about people's care and how the home was managed. These included care records and medicine administration record (MAR) sheets for four people and other records relating to the management of the home. These included staff training, support and employment records, quality assurance reports, policies and procedures, menus and accident and incident reports.

Oak House Care Home was last inspected on 16 May 2013 and there were no concerns.

Requires improvement

Is the service safe?

Our findings

Communal areas of the home were clean and free from unpleasant odours. However, during our inspection we found a strong odour coming from two people's bedrooms. When we explored this further we found that one person's bed had been made despite the mattress being soaked in urine. In the second person's room there was a used continence pad on the window sill and their bedding was stained and smelt of a strong odour. The manager told us, "The domestic cleans the rooms daily but she was on leave. She was due back Saturday but didn't return to work so we have all being doing bits of cleaning. We now need to recruit someone". Staff rotas confirmed that the domestic shifts had been covered whilst the member of staff was on planned leave but not since Saturday 18 July 2015 when they should have returned to work. As a result cleanliness and infection control measures had not been maintained to satisfactory levels. Failure to have effective arrangements in place to ensure the premises is clean and hygienic is a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

In response to our concerns the manager arranged for carpets to be deep cleaned whilst we were still at the home. Within 24 hours of our inspection they also confirmed in writing that domestic cover had been put in place whilst new domestic staff were recruited and that further deep cleaning of beds and carpets would take place by the homes maintenance team.

People who lived at the home and staff told us that there were enough staff on duty to support people at the times they wanted or needed. One person said, "There are enough staff". A Community Psychiatric Nurse wrote and informed us, 'I am always given a quiet area to see clients and offered a member of staff to be present if I need one'.

Staffing levels consisted of three care staff during the day and two care staff during the night. In addition to the manager and care staff a cook and domestic person were allocated on shift seven days a week. The manager told us that staffing levels were decided by, "Looking at the dependency levels of people and if staff struggled. I observe day to day". The manager informed us they were in the process of advertising for an activity person and that this would increase the numbers of staff deployed on shift and would benefit people who lived at the home. We observed that staff were available when people needed assistance with personal care. The home had a call bell system in place that enabled people who chose to stay in their rooms to call for assistance when needed. When this was activated we observed that staff responded promptly.

Recruitment checks were completed to ensure staff were safe to support people. Three staff files confirmed that checks had been undertaken with regard to criminal records, obtaining references and proof of ID. They also included checks on eligibility to work in the United Kingdom and completed applications forms. Staff confirmed that thorough recruitment processes had been followed before they commenced work at the home.

The manager and staff told us that the majority of people at Oak House Care Home lived with dementia. Some people were unable to communicate with us verbally, but others told us they felt safe. One person said, "Yes I feel safe" and another said, "They treat me well". A relative said, "He is very safe here. My sister and I feel very lucky to have found here". We observed that people looked at ease with the staff that were caring for them.

Staff confirmed that they had received safeguarding training and were aware of their responsibilities in relation to safeguarding. One member of staff said, "Our aim is to help the residents and keep them safe. If there are any problems, we report it to the person in charge or the manager. I know they will report it to social services and CQC. I would ensure that I write it down and I would also make sure that the resident is safe." Staff also told us that if they were not satisfied with how the issue had been dealt with by management they would speak to CQC.

The manager demonstrated knowledge and understanding of safeguarding issues in line with her position. She was able to explain when and how to report allegations to the local authority and to the CQC.

Risks to people were managed safely and people were able to make choices and take control of their lives. For example, one person had been assessed as at risk of choking and advice and support had been obtained from a Speech and Language Therapist (SALT) who recommended a pureed diet. The person concerned did not wish to have a pureed diet and further advice was sought from the SALT and the risks and benefits explained to the person. The

Requires improvement

Is the service safe?

person still did not wish to have a pureed diet and records confirmed that other actions had been put in place that allowed the persons choices to be respected whilst still managing the risks to their wellbeing and safety.

Risk assessments were in people's care records on areas that included moving and handling, falls, behaviour and skin integrity including pressure ulcers. People had pressure mattresses, hospital profiling beds, pressure relieving cushions and sensory mattresses to ensure they were kept safe and to reduce the development of pressure areas. Accidents and incidents were looked at on an individual basis and action taken to reduce, where possible, reoccurrence. For example, a door sensor was in place on one person's bedroom door to alert staff of their movements at night as they were at risk of going into other people's bedrooms due to memory loss. We observed staff supporting people to move safely from wheelchairs to armchairs in the lounge using moving and handling equipment.

Equipment had been checked to ensure it was safe for people to use. These included checks and servicing of gas supplies, hoists and the lift, emergency lighting and safety checks on small portable electrical items. Personal emergency evacuation plans were in place for each person that would help them be moved from the home in the event of a fire.

We looked at the management of medicines at Oak House Care Home and observed their administration to people during the morning period. The member of staff who administered people's medicines did this safely and with consideration for people who lived with dementia. The member of staff knelt beside people and explained what medicines were being offered and why. People were given time to take their medicines before the member of staff recorded that these had been taken. Medicines were stored safely in a locked trolley which was not left unattended when open. The member of staff described how they completed the medication administration records (MAR) and we witnessed this during the medicines round. A member of staff told us, "All staff who administer medicines, receive training and are assessed by the manager to ensure they are competent before administering medication to residents."

Medicines were ordered in a timely fashion for continuity of treatment. There were systems in place for ordering and disposal of medicines. There were guidelines for the administration of medicines required as needed (PRN). Staff knew when PRN medicines should be given and why. Staff were able to explain the safe procedures that they followed for the receipt, storage, administration, recording and disposal of medicines that included controlled drugs.

Requires improvement

Is the service effective?

Our findings

The manager did not understand the Mental Capacity Act (MCA) 2005 and the requirements under the Deprivation of Liberty Safeguards (DoLS). The safeguards under DoLS protect the rights of people by ensuring if there are any restrictions to their freedom and liberty these have been authorised by the local authority as being required to protect the person from harm. The manager said that she had completed training in these areas but could not explain sufficiently people's rights or her responsibilities in relation to upholding their rights. She was not aware of a Supreme Court ruling in April 2014 that placed additional responsibilities on services where people lived who could not leave freely and without supervision.

The manager had not ensured people's rights were upheld if they lacked capacity to consent in line with the MCA. They told us that no one who lived at the home was subject to a DoLS authorisation and that, "I've not needed to do any applications". We saw that there was a key coded lock on the front door. The manager and staff confirmed that many people who lived at the home were unable to consent to the use of a locked front door due to them living with dementia. Individual assessments had not been completed that considered people's ability to consent to this or for actions that should be taken if people did not have capacity to consent. The manager said that "Probably two thirds of people" lacked capacity to consent to the front door being locked. The manager confirmed that best interest processes had not been followed for people who did not have the capacity to consent. The manager had not completed mental capacity assessments or made DoLS applications and as a result people's rights had not been promoted. Failure to act in accordance with the requirements of the MCA 2005 is a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Despite formal consent processes not being followed in full for people who lacked capacity to consent, staff checked with people that they were happy with support being provided on a regular basis and attempted to gain their consent. Staff sought people's agreement before supporting them and then waited for a response before acting on their wishes. Staff maximised people's decision making capacity by seeking reassurance that people had understood questions asked of them. They repeated questions if necessary in order to be satisfied that the person understood the options available. Where people declined assistance or choices offered, staff respected these decisions.

With regards to consent, a member of staff explained, "It is about choice, and the ability to express their needs, it is what they needs as long as it is safe. You must get consent, you have to respect their choice, it is their choice not ours. There are different ways to communicate with people, such as us sign, pictures, written language or body language".

People said that they were happy with the support they received from staff. One person said, "It's very good here". A second person said, "I can't fault the care here. I am very happy here". A relative said, "Everyone is so pleasant". A second relative said, "He is very well looked after. He is catered for in every way. The staff are lovely here".

Staff were sufficiently skilled and experienced to care and support people to have a good quality of life. Staff confirmed that during their induction they had read people's care records, shadowed other staff and spent time with people before working independently. Training was provided during induction and then on an ongoing basis.

Staff were trained in areas that included first aid, fire safety, food hygiene, infection control, medication and moving and handling. A training programme was in place that included courses that were relevant to the needs of people who lived at Oak House Care Home. Staff confirmed that they had attended training that included dementia care, end of life, equality and diversity and nutrition. Staff were provided with training that enabled them to support people appropriately.

Staff received support to understand their roles and responsibilities through supervision and an annual appraisal. Supervision consisted of individual one to one sessions and group staff meetings. All staff that we spoke with said that they were fully supported. Records confirmed that since the manager had been in post seven of the 11 staff employed at the home had received a one to one supervision.

People said that the food at the home was good. Comments included, "Food is ample", "Food is good" and "I like the food here; they take great care of me." During the

Is the service effective?

morning we observed that two people were having their breakfast at 10.30am and 11.30am. This showed that there was flexibility in the home and that people had a choice as to when they ate.

We sat and joined people for lunch. The large, bright dining room had tables that were attractively laid with clothes, napkins, cutlery and condiments. A picture menu was placed on the tables that helped people who lived with dementia recognise the meals being served that day. The servings of lunch were generous. People were offered a choice of vegetables which were broccoli and carrots or mixed salad to go with home-made pizza. There was a choice of homemade tomato sauce or gravy. Dessert was apple sponge and custard or yogurt. We observed that most people ate a good plateful of food. Every person had a glass of fruit juice with their meal and tea or coffee was served after the lunch.

Specialist cutlery was provided that allowed people to eat independently. One person who was seen using specialist cutlery told us, "The cutlery is very good; they are big, so I can hold them."

In-between the main meals of the day we observed that people had access to a good choice of drinks and snacks. For example, slices of fruit and grapes were offered to each person in the lounge in the afternoon followed later by cake with a cup of tea.

Staff were present during the lunchtime period who offered assistance to people when needed. They did this with consideration and sensitivity. They sat next to people who they assisted, and supported people at their individual pace whilst offering words of encouragement. Two people were given pureed meals which looked unappetising as the individual food items had been mixed together and served in a deep cereal/soup bowl. The food looked quite stiff and a member of staff offered a drink regularly, having to coax one person to eat the meal. Having tasted the first mouthful one person said, "It's awful" and made a facial expression of dislike.

Care plans included information about people's dietary needs and malnutrition risk assessments. Care plans included people's food likes and dislikes, food allergies and specific dietary preferences. The chef was knowledgeable about the dietary needs of people. Where people were at risk of malnutrition or dehydration fluid input charts had been completed. However, these had not been checked by anyone or had the amounts totalled to ensure people received further support to maintain good fluid levels when needed.

Within 24 hours of our inspection the manager confirmed in writing that all staff had been instructed to ensure that food and fluid charts were totalled daily. Staff had also been instructed to ensure pureed foods were blended and served individually.

People were supported to access healthcare services and to maintain good health. This included calling the doctor promptly as required and also having access to chiropodists, opticians, dentists and district nurses. One person attended a routine optician appointment where concerns with their eyesight were identified. As a result they were referred to a hospital and placed on a waiting list to have cataracts removed. Another person with diabetes attended annual checks with a diabetic nurse to ensure all aspects of their condition were monitored. People's weight was monitored and appropriate action taken when issues were identified. This included referrals to the Speech and Language Team. A Community Psychiatric Nurse wrote and informed us, 'I am happy to be able to say that in my experience this is the best care home in West Elmbridge, which is the area I cover in my position as a Community Psychiatric Nurse. I have placed many clients in Oak House over the last 10 years, confident that all their care needs would be met'.

Apart from names and photographs on bedroom doors there was little pictorial signs displayed on toilets, bathrooms and bedrooms to help people orientate independently. Hand rails were painted the same colour as walls which did not help people who lived with dementia to orientate around the home independently. People's bedrooms were personalised with possessions such as pictures. However we saw no evidence of anyone's individual or personal interests integrated into the home outside of their rooms.

We recommend that the provider researches and implements relevant guidance on how to make environments used by people who live with dementia more 'dementia friendly'.

Good

Is the service caring?

Our findings

People said that they were treated with kindness and respect. One person said, "The staff are kind". Another person said, "Staff are polite and nice". A relative said, "Everyone is so pleasant".

People were spoken to with respect by staff when assisted to move. They explained the process to people, telling them what was happening and provided reassurance. For example, one person was observed being supported to get up from a chair using a walking frame. Staff encouraged the person to do as much for themselves as possible. They said, "I will help you to change, can you lean forward please? That's it, that's good. Slowly turn, very good".

Positive, caring relationships had been developed with people. We saw frequent, positive engagement with people. Staff were seen to be respectful and polite to people calling them by their preferred name. Staff patiently informed people of the support they offered and waited for their response before carrying out any planned interventions. The atmosphere was relaxed with laughter and banter heard between staff and people. We observed people smiling and choosing to spend time with staff who always gave them time and attention. Staff knew what people could do for themselves and areas where support was needed. Staff appeared dedicated and committed. We observed people approaching the manager and vice versa. It was apparent that people felt relaxed in the manager's company.

The manager told us that she had made contact with the headmistress of a local school and was looking to arrange visits in order to build relationships with the local community.

People were supported to express their views and to be involved in making decisions about their care and support. A relative said, "I am consulted on everything for my relative". Each person was allocated a key worker who co-ordinated all aspects of their care. Some people had signed their care plans which indicated they had been involved in their compilation. People told us that they were able to get up and to go to bed at times that suited them. The manager told us that she was going to introduce residents and relatives meetings as another way that people could express their views.

People's privacy and dignity was promoted. When people needed assistance with personal care we observed that staff did this behind closed doors in bedrooms and bathrooms. People wore clothing appropriate for the time of year and were dressed in a way that maintained their dignity. People had been supported with their personal care and attention to detail was apparent. Some people were seen wearing colour co-ordinated outfits and non-slip footwear. Several people were wearing clean reading glasses and many ladies had their nails painted. Staff knew people's individual likes and dislikes without the need to refer to their care plans.

People's preferences were reinforced in their care plans. For example, one person's care plan stated, 'I like to look smart every day. I have been very independent all my life and dignity and independence are very important to me. I would like to be empowered to do for myself as much as possible'.

Good

Is the service responsive?

Our findings

People received personalised care that was responsive to their needs. One person was observed to spill a drink on themselves. They made a sound of distress and a member of staff immediately responded. They activated the call bell system and another member of staff responded within three minutes. Both members of staff then assisted the person to leave the room to change their clothing.

During lunchtime, we observed an occasion when a person started to cough when they were eating. Immediately a member of staff responded to the person by ascertaining if they were okay. The member of staff asked if they would like assistance which they declined. Staff explained to the person, that they need to eat more slowly otherwise they might choke. The person followed staff instructions and managed to continue eating without any further incidents.

Another person's records detailed how their health had improved in response to support they had received since living at the home. An external healthcare professional recorded, 'X had received four months rehabilitation whilst at Oak House Care Home. He has responded well. He can now walk with supervision and manage the stairs with a rail and prompting'.

One person told us that they are able to do want they want, come and go as they liked and were able to see a doctor when required. They told us that their relative is able to visit the home at any time of the day to fit in with their work.

Care plans were in place that provided detailed information for staff on how to deliver people's care. The files were well- organised and contained current and useful information about people. Care records were person-centred, meaning the needs and preferences of people or those acting on their behalf were central to their care and support plans. Records included information about people's backgrounds, likes and dislikes and current care needs. They also included information for staff about how individual needs should be met. For example, one person's health promotion plan stated 'I have been diagnosed with non-insulin diabetes mellitus. My diabetes is controlled by diet. I have been diagnosed with alcohol related dementia. I also suffer from epilepsy and am prescribed anti convulsing medication. Sometimes I have seizures and I require staff to follow my risk assessment at time of seizure. I would like to have my eyes checked by optician at least once a year. I would like to be seen by chiropodist every six weeks or more often if I need it. I would like staff to administer my medication due to my forgetfulness'. Records were in place that evidenced the contents of the care plan were being complied with and that as a result the person's individual needs were being met.

People told us that they did not have any complaints and that they felt comfortable to raise issues with staff. One person said, "I'm happy thanks". A relative said, "I've no complaints".

People were supported to raise concerns and complaints without fear of reprisal. People were routinely listened to and their comments acted upon. For example, a member of staff told us, "People can complain by writing to the manager or face to face discussion, they normally talk to us and we sort it out. For example, a resident had loose dentures and kept playing with their dentures, or spitting them out, which caused them to dribble and the relatives, were not happy. After they explained the situation and they saw for themselves what was happening and what we were trying to do to resolve it, they were happy." Staff were seen spending time with people on an informal, relaxed basis and not just when they were supporting people with tasks. The manager told us, "I want people to feel they can raise concerns, suggestions, that they are welcome". The manager said that since she had been in post from April 2015 she had not arranged any residents or relatives meetings but was going to plan for these to occur.

The home's complaints procedure was displayed in the home in order that people could refer to this if needed. Information about how to make a complaint was also included in the home brochure which was given to each person when they moved into Oak House Care Home. There was a complaint folder in place that detailed the last formal complaint received was in February 2013.

We looked at the recent activity records of five people for a three week period which evidenced that people had participated in arts and craft sessions, watching television, puzzles, ball games and listening to the piano. They also confirmed that a BBQ had been held in the garden of the home. The manager told us that until an activity person was recruited all staff were supporting people to participate in activities. She also informed us that she was looking to expand the activities people could participate in

Good

Is the service responsive?

and had arranged for someone to visit the home the week after our inspection to play the cello to people. The manager also said that she was planning a day trip for people and that she was in the process of exploring different venues. During the afternoon we observed a member of staff playing a board game with one person and at another point a member of staff throwing a balloon to three people.

One person wanted to go outside in their wheelchair but there was a raised ledge restricting the access to the garden in the wheelchair they were using. A member of staff offered to move the person into another wheelchair but the person declined and took themselves back to the lounge. The need for improved access to the garden was identified in the development plan for the home. This stated that this would be addressed in August 2015.

Information about activities was on display on a board in the entrance hall of the home. However, the board was placed too high for people to easily access the information and the print size of the information was small and did not make it easily identifiable for people who lived with dementia.

Some effort had been made to the environment in response to people who lived with dementia. A small lounge included fibre optic sensory lights. Staff told us that they assisted people to use this facility. However, the sensory lights were not switched on during our inspection and no one was observed using this room for sensory stimulation. There was not much physical stimulation such as interactive tactile activities or textured surfaces around the home for people that would have provided people with something to do during the day when organised activities were not happening. The manager was aware of the need for more physical stimulation and this was included in the development plan for the home with a target date of September 2015.

Good

Is the service well-led?

Our findings

The manager had been in post since April 2015. Everyone expressed the view that the manager was approachable and friendly and that the home was well led. Staff said that as the manager had worked at the home previously they were confident in her abilities. The manager said, "I like staff to feel free to talk to me, also use supervision, staff meetings, formal and informal systems". We had a BBQ for family and friends recently which everyone enjoyed. Have a separate staff party. This was started by the previous manager and I've continued this. Having a new manager can be unsettling, as it brings changes to ways of work. I'm aware of this". A Community Psychiatric Nurse wrote and informed us, 'I was delighted to learn that X (name of manager) has taken over the role as manager, as I have worked with X in various care homes over the years and the care she provides is on an equal par to X (previous manager). I have had heard nothing but praise for the care in Oak House feedback to me by relatives'.

With regard to the vision and values of the home the manager said, "I want outstanding care at all times. The company logo is 'care without compromise'. The core values of the home were recorded in the homes statement of purpose as 'Privacy, dignity, independence, choice, rights and fulfilment'. The manager said that she intended to discuss these with staff in future staff meetings and supervision sessions in order that they were understood by everyone and embedded in the care that people received.

Staff said that they were consulted and information was shared with them. A member of staff said, "I really enjoy working here, I don't want to leave". Another member of staff said, "There was a staff meeting last month, we discussed staffing issues, residents, and how you can improve the service and any concerns about the job. For example, I asked for Equality and Diversity training as I felt it would be beneficial and I got it." Records confirmed that a staff meeting was held in May 2015. During this meeting the manager also reinforced to staff that they 'should feel free to talk to her at any time'.

The home produced a newsletter that helped people to be informed of changes and events. The summer 2015 newsletter informed people about the new manager, additional activities during the summer and changes in staff who worked at the home. The newsletter included the use of coloured photographs which would help those who lived with dementia to understand the contents.

There was a system of quality assurance audits in place that helped ensure quality standards were maintained and legislation complied with. These included audits of accidents and incidents, medicines, care records and complaints. Some of these had not been completed at the frequency stated on the audit forms. For example the 'Monthly medication audit' was last completed in February 2015. There was a two month gap in the monthly weight audit for people in March and April 2015 but this had improved and a monthly audit resumed from May 2015. The manager was aware of the gaps in monitoring systems and had set a target date of 31 August 2015 for improvements in this area to have been achieved. The manager has been in post since April 2015. She informed us that she had prioritised the reviewing of peoples care packages as, "The reviews are a good way of getting to know people". Records confirmed that these had been arranged for eight people at the time of our inspection and plans were in place for these to be completed for everyone by 31 July 2015. The manager said that she had not yet sent out questionnaires to people and their relatives as she wanted people to get to know her. The manager said that she aimed to send out questionnaires, "In a couple of months' time".

Prior to the manager being in post questionnaires were last sent to people in 2014 (the specific date was not recorded). Of the 13 questionnaires sent to relatives of people, five were returned. All had responded the home was either 'very good' or 'excellent' when asked the questions, 'How do you rate the friendliness and helpfulness of staff'. Four people who lived at the home returned questionnaires in 2014. Again people responded the home was either 'very good' or 'excellent' when asked if they were happy with the care provided.

There was a development plan in place for the home that detailed improvements to the decoration and furnishing. Improvements that had taken place included decoration of eight bedrooms, the replacement of some carpets and beds and a gazebo for the garden. This demonstrated a commitment for the environment to be continually improved.

Good

Is the service well-led?

There were whistle blowing procedures in place which the manager said were discussed with staff during supervision and at staff meetings. Discussions with staff confirmed this. Staff confirmed that they were aware of the whistle blowing procedures and were able to explain what these were when asked.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent **The registered person had not acted in accordance with the Mental Capacity Act 2005 for service users who were unable to give consent. 11(3).**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment **The registered person had not ensured all parts of the premises were clean. 15(1)(a).**