Surrey Rest Homes Limited

Oak House Care Home

Inspection report

Oak House
19 Queens Road
Weybridge
Surrey
KT13 9UE

Tel: 01932849844
Website: www.surreyresthomesltd.co.uk

Date of inspection visit:
16 August 2018

Date of publication:
10 October 2018

Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

Oak House Care Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Oak House is registered to provide accommodation and personal care for up to 16 people. There were 14 people living at the service at the time of our inspection.

This inspection site visit took place on 16 August 2018 and was unannounced.

There was no registered manager in post on the day of the inspection. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. We were supported by the provider on the day of the inspection. The manager that had been recruited at the service had handed their notice in. Instead we were supported by the provider.

At the last inspection in July 2017 we asked the provider to take action to make improvements in relation to the quality assurance and record keeping at the service. We found that these actions had not been completed. At the previous inspection we also made recommendations around how complaints were responded to and staffing levels. We found staff levels had improved however there was still concern around how complaints were recorded and dealt with.

The premises and equipment was not maintained to a safe standard. Audits were not effective in identifying these shortfalls. Risks to people were not managed safely. There was a lack of detailed guidance for staff to assist them to support people. Monitoring tools were not used effectively where people were at risk of malnutrition and dehydration.

Accidents and incidents were not analysed to look for trends. Robust recruitment had not taken place to ensure that appropriate staff were employed.

Staff were not always working within the principles of the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS). The premises adaptation did not meet the needs of people that were living with dementia.

Before people moved in to the service a full assessment of their needs did not always take place. Care plans were either not in place or did not always include all the necessary information or guidance for staff including end of life care planning. Activities were not always person centred and people did not have appropriate opportunities to go out.

Staff had not always received training or supervision in relation to their role. However, there were aspects of

staff practice that was appropriate and in line with correct protocols.

We found that people were not always involved in the planning of their care and did not have choices with day to day care. People did not always receive effective support with their personal hygiene.

Records of complaints were not kept and complaints were not always addressed appropriately. Quality checks that were taking place were not effective and audits did not always identify the shortfalls that we identified. Improvements were not always made as a result of feedback.

Safe levels of staff were maintained, staff protected people from the risk of abuse and there were systems and information in place to keep people safe in the event of an emergency. The management of medicines were safe.

People were offered choices of meals and drinks. People were supported to maintain their health and had access to health care professionals. Information about people's care was being communicated effectively between staff.

We did see examples of people being treated in a caring and respectful way by staff. People were supported to practice their faith and visitors were always welcome to the service.

Staff told us that they felt supported by the staff team. Where appropriate notifications were sent to the CQC.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was consistently safe.

Robust recruitment checks were not in place to ensure that only suitable staff worked at the service.

The environment was not always being maintained in a safe way.

Risks to people were not being appropriately identified or managed. Accidents and incidents were not analysed to look for trends.

Medicines were managed in safe way. Staff were following good infection control.

There were appropriate plans in place in the event of an emergency at the service in relation to the service.

There were sufficient staff to meet the needs of people.

There were effective safeguarding procedures in place to protect people from potential abuse. Staff were aware of their roles and responsibilities.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff were not acting in accordance to the Mental Capacity Act 2005. People's capacity had not always been assessed and DoLS applications had not been made for people that had capacity.

Pre-admission assessments were not always taking place.

Staff were not always provided with appropriate training and supervisions although we did see aspects of care that was competent.

The environment did not meet the needs of people living with dementia.

Staff effectively communicated across the service.

People enjoyed the food at the service. People had a range of nutritious food and drink.

People had access to health care professionals specific to their needs.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People did not always have a choice around their care delivery. People were not always supported with their personal hygiene.

People's rooms were personalised. There were times where people were supported with their independence.

We did see occasions where staff treated people with dignity and times where staff were kind and attentive.

People's relatives and friends were able to visit when they wished and people were able to practice their religion.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People and their relatives were not involved in detailed discussions about end of life care. Care plans were not always in place and care was not always reviewed on a regular basis.

People did not always have access to person centred activities and people were not able to go out when they wanted.

Complaints were not always investigated, recorded and responded to in a timely way.

Other information regarding people's treatment, care and support was reviewed regularly and shared with staff.

Is the service well-led?

Inadequate

The service was not well-led.

The provider continued to breach a regulation from the previous inspection.

There was not adequate management and leadership at the

service.

Quality assurance processes were not being used as an opportunity to make improvements. Audits were not robust in identifying shortfalls.

Staff told us that they felt supported by the team.

Staff were working with outside organisations to support people's health needs.

Notifications that are required to be sent to the CQC were being done.

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 site visit took place on 31 July 2018 and was unannounced. The inspection team consisted of two inspectors.

Prior to the inspection we reviewed the information we had about the service. This included information sent to us by the provider, about the staff and the people who used the service. We reviewed notifications sent to us about significant events at the service. A notification is information about important events which the provider is required to tell us about by law.

We reviewed the Provider Information Return (PIR). The PIR 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.

During the visit we spoke with the provider, four people, one visitor and six members of staff. There were people that were unable to verbally communicate with us; instead we observed care from the staff at the service. We looked at a sample of three care records of people who used the service, medicine administration records and four recruitment records for staff. After the inspection the provider sent us further information that related to staff training and supervision and quality assurance.

In addition, we made calls to three relatives of people using the service.

Requires Improvement

Is the service safe?

Our findings

We asked people whether they felt safe living at the service. One person told us, "I feel safe. There is no reason to worry." Another told us, "I feel as safe as I can be here". A third said, "I used to fall and I have had less falls here but the staff are there to help". One relative told us, "I feel dad is safe, I have never had a reason to feel he isn't. Whenever there is a problem with dad staff are on it." Another said, "I have never felt that she [their family member] isn't safe." Despite this feedback there was aspects of the care that put people at risk of unsafe care.

The premises and equipment at the service was not always maintained appropriately to keep people safe. One relative told us, "The building is old, tired and weary. They [the provider] only do superficial fixing." In one person's en-suite the toilet was continuously filling causing a loud noise in the person's room. The person told us that this happened a lot. This had not been reported by staff to the maintenance team to fix. In another person's room there was no window restrictor on the person's window and the window was wide open. This posed a risk to the person and others of falling from the window. During the inspection we were advised that there had been a water leak in the flooring of a communal corridor. Where the flooring had been removed to fix the leak, there was loose concrete as well as three small holes which were a risk to people walking through the corridor. We saw people accessing this area to reach their rooms throughout the inspection. The chairs in the lounge were stained and needed cleaning or replacing. The building and refurbishment policy at the service stated, "All material parts of the premises, including fixtures and fittings, will be well maintained and incorporated within the rolling programme of buildings improvement." We found that this was not the case.

The equipment at the service was not always appropriately located for their intended purpose. The service hoover was being stored in a downstairs boiler room with a step down. When the hoover was being used the door of the boiler room was left open which put people of risk of falling down the step. The hoover was plugged in the hallway and the cord was in the way of people access the corridor causing a trip hazard. The laundry room was small and there was no area for staff to place soiled rubbish. Instead staff were propping a large black filled with rubbish in between the washing machine and the tumble drier.

The PIR states, "Our residents feel safe as they know that any equipment we use is safely installed, maintained and tested regularly as well as before and after use. They are checked they are fit for purpose and are clean and ready to be used again." This was not the case on the inspection. We brought all the concerns regarding equipment and premises to the attention of the provider who assured us they would start to address this.

As the environment had not been well maintained which did not promote safe care this is a breach of regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Risks to people's care were not always managed safely. There were people at the service that had diagnosed mental health conditions. We found that there were no risk assessments or management plans around this that staff could follow to provide safe care. For two people that had recently moved in to the service there

were no risk assessments in place for them. This had also been identified by the providers through a recent audit. We saw examples of where care was not always taken to ensure that people's teeth were cleaned. The provider told us that concerns had been raised by a health care professional that one person's dental hygiene required improvement. All of people's toothbrushes on the day of the inspection looked dry and as though they had barely been used. One person told us that staff rushed in in the early morning to get them up. A relative told us, "Sometimes the personal hygiene is not done very well. His [their family members] teeth are not very clean and he isn't shaved particularly well."

People's nutritional and hydration risks were not always managed safely. Where people were on a food chart staff were not always analysing the information, or recording accurate information. For example, one person was at risk of malnutrition and they had been losing weight. Staff were inconsistently recording information on what they had eaten. At times staff were writing the type of food the person was offered but not whether the person had eaten it. One person required a fluid chart to ensure that they were meeting their hydration needs. However, staff did not monitor the amount of fluid intake of that person daily to identify if any further action was required and there were no target amounts.

One person who remained in bed every day and relied on staff for every aspect of their care and welfare looked to have a dry mouth. The member of staff who came to give them their medicines at lunch time offered them a drink of thickened fluid which they drank quickly. Their fluid chart showed they had not had a drink since 10.30 that morning. We pointed this out to staff and a senior member of staff instructed staff to attend to the persons mouth care. Staff said they attended to check on this person every hour or so but no drink had been given and no staff had noticed their need for mouth care until lunch time.

Staff completed accident records which gave detail of the accident or incident and the immediate action taken to get medical advice or to protect people from harm. However, the provider did not check or analyse the records to look for trends see if any action could be taken to prevent further accidents. The PIR stated, "We read and write risk assessments and implement any changes which will reduce the likelihood of reoccurrence." We found that this was not happening routinely. One person had daily behaviours that were recorded however their risk assessment was not in place in relation to these behaviours to help guide staff. There was no analysis of their behaviours or steps taken to reduce further risks.

Failure to safely manage risks to people is a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were not protected from being cared for by unsuitable staff because robust recruitment procedures were not in place. Out of the three recruitment files we looked at one did not hold any references and one contained only one reference. There was limited information on the history of staff past employment and only two of the files contained an application form. The provider has informed us since this inspection that steps are being taken to improve this aspect of safety. We will assess this at our next inspection. Staff had therefore been working without the provider taking steps to ensure that they were suitable. The service recruitment policy stated, "All offers of employment are made on condition that a minimum of two satisfactory written references are obtained in respect of the applicant, one of which will be from the person's most recent employer, where this is applicable." They were not following their own policy. All staff had undertaken enhanced criminal records checks. The PIR stated, "We follow safe recruitment procedures and disciplinary procedures when necessary." We found that this was not the case.

Recruitment procedures to ensure that staff employed were fit and proper were not followed, this is a breach of regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the previous inspection we made a recommendation around ensuring that there were appropriate levels of staff to support people at meal times. During this inspection this was not a concern. There were mixed responses from relatives about staff levels. One told us, "I think there are enough staff." Another told us, "There is no continuity of staff. There never seems to be enough staff." We observed that there were enough staff to assist people with their hygiene and personal care needs but not to allow people to be accompanied out to local places or on trips. Since the inspection the provider has informed us that trips are now taking place weekly, following risk assessments and family agreement when needed. One person said, "The staff are fine, they help me when I need it". Another person said, "When I ask the staff are there to help me". There was normally one senior, three carers, a chef and cleaner working each day and two carers at night. Occasionally this dropped to two carers in the day if staff went off sick at short notice. Staff absence was covered with existing staff as the provider told us some staff lived on site and so they were asked to work extra shifts. There were enough staff at lunch time to assist anyone who needed help with their meal and people were not waiting long to have help with their needs. We checked the rotas and found that there was always the safe level of staff allocated.

Other than the stained chairs in the lounge and the lack of space in the laundry room, people were protected against the risk of infection as appropriate measures were in place. The service was clean and a member of staff worked to maintain cleanliness. There was a daily cleaning checklist which staff completed. Staff had personal protective equipment available and used this when caring for people or preparing food. There was a sign on the kitchen door to remind staff to wear aprons at all times when entering. Each bathroom and toilet contained hand wash, paper towels, gloves and the bins for general and clinical waste were covered. We saw staff wearing gloves and aprons where appropriate. They were able to describe the process of ensuring infection control. For example, one member of staff described the process of how soiled and non-soiled laundry needed to be washed separately. Another member of staff explained what they would do when emptying and cleaning people's commodes and the importance of hand washing. One relative told us, "When I look in her [their family member] room it's always clean and tidy."

There was a business continuity plan in the event the building needed to be evacuated. Safety checks were carried out on equipment and fittings and fire safety checks and drills had taken place. There was a grab bag in the for emergencies and this included a personal evacuation plan so emergency services would know how to assist each person to leave safely.

One care plan contained risk assessments including guidance for staff on how to maintain skin health, pressure sore prevention, falls, malnutrition and diabetes. A member of staff was able to describe this person's needs and risks and what action needed to be taken to try to prevent the risks. They were at high risk of falling and there was clear guidance for staff in assisting them safely. The person used a stick or a frame at different times and we saw staff walking beside the person, as required, to steady them when they walked to the lounge. Staff knew the person required cream applied to their skin and to be helped to move to prevent remaining in one position for too long. The daily notes showed that staff had ensured that this person moved to try to prevent any pressure sores. One person had a long-standing pressure sore as they remained in bed but they were receiving treatment from nurses and had been assessed by a tissue viability nurse.

People received their medicines as prescribed. Only one person we spoke with was able to understand the medicines they took and for other people the staff tried to explain what they were being given. Medicines were stored, administered, recorded and disposed of correctly. Only staff who had been trained were giving people medicines. The member of staff we observed giving the medicines had completed a short refresher course the week before and was knowledgeable about good medicine practices. Staff had guidance for giving the correct doses at the right times for PRN (as required) medicines and the member of staff was

checking if people were in pain before giving any PRN pain relief. The staff followed good hygiene practice when administering medicines and they explained to people what their medicines were for and made sure people took the medicines before signing that it had been given. The records were maintained accurately. The medicine trolley was well organised and clean as was the medicine fridge. Regular temperature checks had been recorded to make sure medicine remained fit for use.

Staff had the knowledge and confidence to identify safeguarding concerns and acted on these to keep people safe. There was guidance and policies available to remind staff of the correct procedures and who to contact if they suspected abuse. One member of staff told us, "I would report it straight away." There were signs and leaflets to alert people, visitors and staff to safeguarding and how they could report any allegations or concerns.

Requires Improvement

Is the service effective?

Our findings

We asked people whether staff asked for consent. One person said, "The staff do ask me if they need to help me with something".

The Mental Capacity Act 2005 (MCA) provides a legal framework for making 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 a person lacks the mental capacity to make a decision, any made on their behalf must be in their best interests and the least restrictive option available. MCA assessments had not been completed where decisions needed to be made in relation to aspects of their care. The provider had undertaken a recent audit of people's care plans and identified that of the 14 people that lived at the service none had an MCA assessed where required.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. These safeguards 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. We noted that DoLS applications had not been completed in line with current legislation to the local authority for people living at the service for example in relation to the locked front door. Since this inspection the provider has informed us that DOLs applications have been completed. We will check this at the next inspection.

As the requirement of MCA and consent to care and treatment was not followed this is a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessments of people's needs were not always carried out before they moved in to the service to establish if their needs could be met. Out of 14 people 11 had been assessed by the staff. and of those 9 had a local authority assessment. However, three people had not been properly assessed. For example, one person had been visited at hospital prior to moving in to the service. Information sought about the person's needs was limited to one word answers on the assessment form. One person could display behaviour that staff found challenging. Information regarding these behaviours was included on a local authority assessment, however this had not been explored by the provider and could have impacted on the decision about whether the service could meet their needs. One member of staff said, "We didn't know enough about her. It would help if we knew more." Another member of staff said they did not know how to cope with this person and they didn't think the person should have been admitted. The service admissions policy stated, "In line with its registration requirements, the home must be satisfied that it has the capacity to meet the needs of any "prospective resident before agreeing to an admission." We found that this was not always happening.

There were occasions where pre-admission assessments were completed. One person had a full assessment prior to moving into the service and this included details about their medical history, their needs and mobility. This had been used to develop a plan of care which staff used to get to know the care the person needed. This care plan contained details about how staff should deliver the right care to meet this person's needs. Staff knew this person's needs and cared for them according to the plan.

The design and adaptation of the premises did not always meet the needs of people. In one person's en-suite the mirror had been placed low down on the wall which meant the person would not have been able to use it. Shelves in people's bathrooms were small and slim making it difficult for people to store their toiletries on there. The provider told us that one person liked having their toiletries out on display in their bathroom. The shelf they were on was not appropriate for this purpose. The position of the television in one person's bedroom had meant that when the person was sat in their chair or in their bed they could not see the screen of the television.

There were people that were living with dementia and improvements were required to ensure their needs were being met. There was not sufficient evidence that consideration had been given to making the service more dementia-friendly. Some bedroom doors had pictures to identify them to their occupants but other bedrooms had nothing to indicate whose bedrooms they were. We found that the chairs in the lounge were arranged around the edge of the wall instead of small clusters to encourage conversation. There was a lack of age appropriate points of interest for example photographs or artworks of a size that could easily be seen, along the corridors.

As people's needs were not always assessed before they moved in and the environment did not always meet people's needs this is breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff did not always have supervisions or appraisals to ensure they were competent to provide care safely. According to the policy, "Each care staff member has an annual staff appraisal with their supervisor, which forms part of the supervision programme…a minimum of six sessions (supervisions) per year" should take place. Only two members of staff had received a supervision with their manager and no appraisals had taken place. The senior carer worked with care staff to ensure they were working to the expected standards but this had not always been recorded with any follow up actions.

Despite this lack of supervisions we found staff were competent. For example, when staff were supporting people to move around. We saw staff helping people to use footplates on wheelchairs and walking with a person who required a walking aid. One person required the use of a sling to help them move and an occupational therapist had trained some staff and videoed what needed to be done and left staff an information sheet so all staff could ensure they were competent. Staff were observed to adhere to appropriate health and safety techniques when handling food in the kitchen. The provider sent us evidence after the inspection that all staff had received training specific to their role.

We recommend that the provider ensures that staff have the appropriate supervision required to undertake their role.

One person told us, "I see a doctor and the chiropodist." A relative said, "They [staff] are always cautious and call the GP on any little thing. They always make sure he [their family member] gets medical attention." Relatives told us that staff were always good at contacting them when their family member was unwell.

Staff said the team worked well together and they communicated with each other about the care people needed or any changes to their health. We saw from records that people had attended appointments with specialists, opticians and dentists. There was a record in one care plan that the person had been seen by a number of specialists and this had been included in their plan for staff to see. One person had developed a urinary infection which the staff had noticed and called in the GP. The person had been treated in hospital and returned home. The staff were aware that repeat tests needed to be done and this had been recorded.

We asked people about the food at the service. One person said, "I get enough to eat and drink." The chef knew people's food preferences and needs well. They had a complete list in the kitchen of how people liked their teas and coffees, who was on soft or pureed diets and who required food supplements. The chef asked people daily which of the two main meal choices they would like and said they would always prepare alternatives if someone did not like the choices. One member of staff had noticed that one person was not eating well so they had contacted the persons family to ask what food they especially liked and staff provided this. We saw that people were weighed on a monthly or weekly basis. Where people were losing weight appropriate health care professionals were consulted.

Requires Improvement

Is the service caring?

Our findings

People had not been consulted or included in planning their own care. Two people said they had not been asked about their care. There was no evidence in care plans that people had been asked about their preferences. People were not always given choices about when they wanted to get up or when they wanted to have breakfast. One member of staff told us that night staff were told that they had to get up seven people before they went off shift. They said, "That leaves day staff to do six or seven [people]." We asked how it was decided who night staff would get up and they said that they would normally choose the same people or, "The senior [carer] would decide."

People did not have a choice on how many baths or showers they could have. One person told us they liked to have a bath but had not thought to ask for more than one bath a week. We saw that there was a rota for when people received their weekly bath or shower. We asked a member of staff what would happen if a person wanted more than one bath or shower. They said, "We would ask the night staff to do the personal care." These routines for people were about managing the workload for staff which meant that people did not have sufficient choices. The service care and support policy stated, "Care and support plan is drawn up with people's involvement after a thorough assessment of the prospective service user's needs, abilities and aspirations." We found that this was not being followed.

People were living in a home environment that was tired and in need of updating. There had been little consideration of the impact that this may have on them. People were not involved in choosing their own preferred routines. Staff were kind and caring but they focussed on the tasks that needed doing rather than people's individual preferences. The hot water had stopped first thing in the morning of the inspection but efforts had not been made to make people still in bed aware of this. One person told us that they had washed themselves with cold water that morning.

One relative told us that due to the strong accents of some staff whose first language isn't English, "It seems as they [staff] don't always understand [their family member]. It comes across as though they are not listening." We discussed this with the provider who advised us that staff are tested on their spoken and written English when they start working at the service. They told us that they would look into this.

As people were not always involved in their care planning and did not always have choices around their care this is a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The bedrooms were worn in decoration and furnishing but they did contain people's personal items and mementos. One person said, "I really like my space, my room, I have photos up of my late husband and friend."

Aside from people not always have a choice around their care we did see examples of people being treated respectively. Staff knocked on people's doors before they entered and any personal care was provided behind closed doors.

Staff showed kindness to people and sat with them when offering food or drinks. When the morning activity was taking place staff were on hand to support people to help people with the game. One person became distressed and staff were there to offer reassurance and support. Relatives had written feedback about the caring nature of staff. One wrote, "I don't know how I would have coped without their [staff] professionalism and care." Another wrote, "You have all been fantastic with your kindness and consideration and it was a great comfort to know that mum was in very good hands." The provider showed kindness to a person by spending time talking and comforting the person who was distressed.

There were no restrictions on visiting and families were welcome. One person was visiting someone they had known for 13 years. They told us, "The staff seem nice and very kind." One relative told us, "The staff are always welcoming and nice." There were regular religious services held at the service for people to participate in should they want to.

Requires Improvement

Is the service responsive?

Our findings

There was a risk of people receiving inconsistent support. Care plans did not always reflect people's physical, mental, emotional and social needs. There were people at the service that did not have a fully developed care plan. One member of staff said, "The manager has not updated the care plans and we only know people because we spend every day with them." The service care and support policy stated, "This care service always develops an individual plan of care which describes what care and support is needed and how it will be delivered." We found that this was not always happening. The provider had sent in a senior member of the management team to review people's care plans. They identified that six people lacked a care plan. Since the inspection the provider has assured us that three care plans were later found so only three people lacked a completed care plan. They were prioritising work on these. There were no care plans in place to show that discussion had taken place with people around their wishes nearing to the end of their life.

Activities were not always person centred and people were not able to access the community. The service social contact policy stated, "Activities at the home are composed of both indoor and outdoor pursuits and include arts and crafts, gardening, photography, keep-fit, swimming, etc. Holidays and short breaks are encouraged as are regular outings to places of local interest and also the taking of small groups to lunch at the local pub." This was not taking place. The provider told us that people did not go out, unless with their families. They told us the manager was supposed to be organising a trip but this had not happened. The provider said, "This is something we should make happen". Staff said that people did use the garden in good weather. We discussed the importance of people going out to local places or further afield for people's wellbeing. The provider told us that there were not enough staff to facilitate this at the moment. One member of staff told us, "It would be nice for people to be able to go out." A relative said, "She [their family member] always loved going out. She would really benefit from that."

During the morning of our inspection an activities organiser ran a bingo session. There were people that were engaged with this and enjoyed the activity. Other people were less engaged and did not appear to know what was happening or fell asleep. One person said, "I love bingo it gets my brain working". The activity person was jolly but once the session started they continued to call bingo numbers without checking that people were keeping up or engaged. They stopped for lunch and returned in the afternoon to carry on playing bingo, with the staff member just continuously calling numbers. In a record of a provider visit on 19 July 2018 it was recorded that the provider has asked the manager to make sure the staff are more aware of these bingo sessions.

Two people were cared for in bed due to ill health. There was no plan for how their potential social isolation would be avoided or how they could be kept stimulated and entertained in line with their likes or wishes. One person's room was quiet with the curtains drawn closed. We asked a staff member if this person liked music or television. They said he liked music. We asked why no music was playing and they told us they [staff] had been busy. We raised this with the provider who said they would look into this. A visitor who was there to visit a person in their room said, "They need a lot of stimulation as they have had a stroke but that does not appear to happen". A relative told us, "There is nothing for [the person] to do. I doubt they [staff] do

anything sensory when I'm not there. I don't think anyone [staff] goes in to provide stimulation to X [their family member]."

Care and treatment was not always provided that met people's individual and most current needs and preferences. This is a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Complaints were not always recorded, investigated and responded to appropriately. On the previous inspection we recommended that complaints needed to be investigated and recorded in full. On this inspection we found that this was still a concern. The provider told us that no official complaints had been received. They said one family had complained verbally that their family member had not had their teeth cleaned and the provider had spoken to them. We did not see a record of this complaint or what action had been taken. We also found a lack of effective oral care for people so this matter may not be resolved to the family's satisfaction. One relative told us that they had complained about a particular issue however this was not reflected in the complaints records.

Staff, people and visitors had a complaints guide available in the hallway. Two people said they could complain to staff. Staff knew they should pass any complaints whether verbal or written to the manager or provider. The complaints policy at the service stated, "Any complaint received must be investigated and necessary and proportionate action must be taken in response to any failure identified by the complaint or investigation. Complaints are responded to in writing by the care service." This policy was not being followed.

As complaints were not always recorded, investigated and proportionate action taken this is a breach of regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service well-led?

Our findings

At the previous inspection we identified that there was a lack of robust quality assurance processes in place. After the inspection the provider sent us an action plan to advise that all of these actions had been addressed and that ongoing reviews of these actions were being monitored by the manager and the provider. However, on this inspection we found that this was not the case and sufficient improvements had not taken place.

At the July 2017 inspection we followed up on a warning notice that was issued in relation to the lack of effective quality assurance at the service. Whilst we found improvements at that inspection the provider had still failed to meet in full the regulation of good governance. The provider had recruited a new manager and a new nominated individual and we were given assurances that the improvements were going to be made and sustained as a result of the management changes. Despite these assurances and an action plan we found on this latest inspection that improvements had not been made and the quality of effective quality monitoring had deteriorated. In addition, the number of regulations that were breached had increased since the last inspection. This showed a decline in the quality and safety of the service people were receiving.

Relatives we spoke with gave their views of how well led the service was. One relative said, "I don't think there is drive to make improvements. There is no consistency with the management. I have felt that the level of care is not excellent. It's just ok." Another told us, "I don't think it's managed very well as there are too many managers." A third said, "There never really seem to be anyone around that you can talk to."

The quality assurance systems were not effective in ensuring the best delivery of care. The manager was required to undertake 'monthly' care plan audits however the last audit took place in November 2017. We identified gaps in care plans that audits would have identified if they were still taking place. On the weekly checklist of 08 August 2018, it was recorded that all care plans had been checked. We identified gaps in care plans and three instances of there being no care plans for people. The provider did inform us since the inspection that 'resident of the day' reviews were taking place which helped to identify care plan gaps and address them. However we still found the planned audits had not all taken place. The audit stated that all staff were up to date with health and safety, moving and handling and first aid training however we found that this was not the case. There was a weekly and monthly manager checklist. The monthly checklist of August 2018 stated that 'Service User Forums' had been planned/completed but this had not taken place.

Audits that took place did not always highlight the shortfalls that we had identified. For example; an audit of the premises was undertaken in August 2018. This had not highlighted that lack of storage for people in their bathrooms, the lack of a window restrictor in one person's room, the poor standard of dining room tables and the poor layout in the laundry room. The Local Authority Quality Assurance team had visited the service in March 2018. They identified that more regular audits needed to take place and for target amounts and totals to be added to people's fluid charts. Despite this recommendation these were still concerns at our inspection around both of these concerns.

Where feedback from people and their relatives was sought action was not always taken to address the concerns raised. For example, in the last relatives survey in June 2017 one relative was asked about the quality of the activities and the décor of the service. They could rate between poor, adequate, good, very good and excellent. They rated adequate which suggested room for improvement. Another said, "I would like to know more about the activities offered." Several relatives mentioned the décor as adequate. There was no action plan from this and no evidence that this had been sufficiently addressed. The last residents meeting took place in February 2017. One relative called and spoke to the manager and asked for more activities to be implemented however this had not taken place. One member of staff (in a meeting with their manager) had asked for additional activities for people however this was not actioned.

The statement of purpose for the service stated, "Oak House Care home aims to provide its Service Users with a secure, relaxed and homely environment in which their care, wellbeing and comfort are of prime importance. Service users are encouraged to participate in the development of their individualised Care Plans in which the involvement of family and friends may be appropriate and is greatly valued." The values of the service were, Privacy, Dignity, Independence, Choice, Rights and Fulfilment. We found that they provider was not working fully to their statement of purpose or their values.

One member of staff said, "I like working here we are a good team but it is difficult at the moment". They said they had been finding it difficult communicating with the manager or getting the manager to action any of the tasks that needed doing. Another member of staff told us that the manager was not checking on the work that they were doing. The provider told us that they had found that the manager had been failing to carry out their duties over at least the last month.

The provider told us, "As far as I'm aware it's been the last month where there are issues. They said, "I will put my hands up. I relied upon X [the manger]. I will admit that now that the audits [that the provider undertook] were not robust enough. I relied too much on the manager." We saw that the manager met with the provider monthly and handwritten notes were made of actions that needed to be completed. However, these were not robust and there were no deadlines for the actions to be completed. According to the notes the provider had been identifying shortfalls in the performance of the manager but sufficient action had not been taken to address this.

As there was a lack of leadership and systems and processes were not established and operated effectively this is a continued breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

On the day of the inspection the manager had been on leave but came in to discuss matters with the provider. The manager handed in their resignation and the provider immediately made arrangements for another manager from one of their other services to come to the service. This manager met with us and described how they had already checked and identified many shortfalls in the care plans and had planned to take action to address the shortfalls. We saw their audit of the previous week which corresponded to the missing information we had identified. The provider confirmed to us that from that day this manager would be spending a number of days each week identifying what actions were needed and implementing changes. This manager had already started to and would continue to identify what improvements were needed and work with the provider and staff. They sent us an action plan shortly after the inspection which included the shortfalls they and we identified and a timescale for making improvements.

There were regular checks of a number of aspects of the service taking place that were effective including, water temperature checks, fire checks and infection control checks. We also saw that a relative had requested for cakes to be provided to people in the afternoon. This had been put in place and we saw that

the menu now included homemade cakes and biscuits at 15.00 each day.

Staff we spoke with did tell us that they felt supported and valued by the people living there and other staff. One told us, "I feel supported by my senior. When I'm stuck and I need information I always go to X [the senior carer.]"

There was evidence that the provider was working with external organisations in relation to the care provision. For example, the provider had regular contact with the GP, SaLT, dieticians and other community care teams.

Services that provide health and social care to people are required to inform the CQC of important events that happen in the service. We found that notifications were being submitted to the CQC where it was appropriate to do so.