Oakhurst Court Limited

Oakhurst Court Nursing Home

Inspection report

Tilburstow Hill Road
South Godstone
Godstone
Surrey
RH9 8JY

Tel: 01342893043
Website: www.oakhurstcourt.co.uk

Date of inspection visit:
16 March 2016

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Oakhurst Court is a care home that provides accommodation, nursing and personal care for up to 57 people. Many of the people at Oakhurst Court are living with dementia. The service also provides respite and palliative care to people. At the time of our inspection 49 people were receiving care.

This inspection took place on 16 March 2016 and was unannounced.

There was a registered manager in place, who was present on the day of the 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 and associated Regulations about how the service is run.

The registered provider has been in breach of regulation 18 since June 2015, Staffing. They had failed to take action in response to requirements for regulation 18 of the Health and Social care act which had highlighted risks to the safety of people and the effective operation of the service.

During this inspection the home did not have a sufficient number of staff deployed to meet the needs of the people who lived there. Care was provided to people by staff who were not always competent to carry out their role effectively. Staff did not always show they had an understanding of the needs of people living with dementia.

People were not always safe living in the home and risks they took were not always minimised. Risk assessments had not been completed for people and staff were not always aware of people's needs.

People's rights were not protected because the staff had not acted in accordance with the Mental Capacity Act 2005.

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 DoLs. We saw related assessments and meetings to make a decision in someone's best interest had not been undertaken.

Care plans did not always contain information to guide staff on how someone wished to be cared for. People were not involved in their care and support. We did not see staff encourage people to do things for themselves. We found staff did not always make people feel as though they mattered or treated them with consideration.

We saw people sitting for long periods of time without social interaction from staff. Appropriate personalised activities for people living with dementia were not always provided.

Medicines were managed appropriately and people received most of their medicines in a safe way. However

PRN (as required) protocols were not robust. We have made a recommendation about this.

Staff understood what safeguarding meant and different types of abuse. We were assured by some staff they knew how to report any concerns they may have. However staff were not always able to identify situations that constituted ill-treatment.

People's views were not obtained by holding residents' meetings and sending out an annual satisfaction survey.

The provider did not have effective quality assurance systems in place, including regular audits on health and safety, infection control, dignity, care plans and nutrition.

At our last inspection we found people were not always supported to have enough to eat. During this inspection we saw a choice of meals was provided to people and people were involved in making decisions about what they ate. However staff did not always support people to eat and drink to support their wellbeing.

At our last inspection we found the environment was not always clean at this inspection the provider had started the process of refurbishment and we saw floors and some beds had been replaced.

The registered manager met CQC registration requirements by sending in notifications when appropriate. We found both care and staff records were stored securely and confidentially.

The provider had ensured they followed good recruitment processes to help them employ suitable staff to work in the home. However the registered manager had not always ensured agency staff had the skills and knowledge for their role.

Staff referred people to external healthcare professionals when appropriate and the local GP was actively involved in the home. We saw that advice and guidance given by these external professionals had been followed and documented by staff.

Complaint procedures were available for people. The registered manager had received complaints and was responding to them. People told us that they had not needed to complain but they went on to say that would feel confident that they could complain and that people would listen to their concerns.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

There were not always enough staff deployed to meet the needs of the people. Agency staff use had increased to ensure safe staffing levels. Appropriate checks were undertaken to help ensure suitable staff worked at the service.

Risks to people's health and welfare were not always minimised effectively and there was an inconsistent approach to the management of risk.

Staff followed good medicines management procedures. However PRN protocols were not personalised.

Staff understood what action to take if they had any safeguarding concerns

Is the service effective?

Requires Improvement

The service was not always effective.

The registered manager and nursing staff did not understand their responsibilities under the Mental Capacity Act 2005 or Deprivation of Liberty Safeguards. Consent to care and treatment was not always obtained as mental capacity assessments had not been completed.

Staff were trained however did not always deliver care effectively in relation to manual handling and people living with dementia.

People were provided with food and drink that met their nutritional needs.

Staff ensured people had access to external healthcare professionals when they needed it. People's changing health needs were monitored by staff.

Is the service caring?

Requires Improvement

The service was not always caring.

People were not supported to follow their interests and take part in social activities. We saw people sitting for long periods of time with little social interaction from staff.

People were not always treated in a dignified way.

Regular staff knew people well and welcomed visits from friends and family.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People or their relatives were not always involved in developing their care, support and treatment plans. Care plans were not personalised and did not always detail daily routines specific to each person.
People were not supported to participate in a range of activities of their choice; there was a lack of individualised stimulation for people living with dementia.

The complaints policy was accessible and people knew how to make a compliant.

Is the service well-led?

Requires Improvement

The service was not always well-led.

The registered manager had not always ensured that effective quality assurance systems were in place to identify and remedy areas of concern or risk in a proactive manner.

There were limited staff meetings held and as a result staff were not given the opportunity to help improve the service.

People who lived in the home and their relatives had not been asked for their opinions of the service.

Notifications of incidents were submitted to the CQC as required by law. Confidential records were stored securely.

Oakhurst Court Nursing Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked 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 16 March 2016 and was unannounced. The inspection team consisted of two inspectors, a specialist nurse advisor (a person who has special knowledge and experience in caring for people with nursing needs) and an expert by experience (a person who has personal experience of using or caring for someone who uses this type of care service.)

On this occasion we had not asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. This was because we were responding to concerns we had received.

As part of our inspection we spoke with 14 people, 11 staff, three relatives, the registered manager, and two healthcare professionals. We spent time in communal areas observing the interaction between staff and people and watched how people were being cared for by staff.

We reviewed a variety of documents which included ten people's care plans, five staff files, and policies and procedures in relation to the running of the service.

In addition, we reviewed records held by CQC which included notifications, complaints and any safeguarding concerns. A notification is information about important events which the service is required to send us by law.

We last carried out an inspection on 15 June 2015 where we identified four breaches in the regulations.

Requires Improvement

Is the service safe?

Our findings

At our previous inspection in June 2015 we found breaches of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 which related to staffing. At this inspection we found that there had not been the required improvements to staffing levels.

People told us there were not always enough staff on duty to meet their needs and that there were "Lots of agency staff." There had been an increase in the use of agency staff by the provider to address the shortfall in staffing levels. One person said when they requested help; "Usually they answer pretty quickly but sometimes they just don't arrive till much later."

During our inspection there were times when there were not always enough staff to support people. People were not always supported to get up when they wanted as staff were busy. One person was not able to get out of bed at the time they wanted despite asking staff several times for their help. This was because other staff were busy helping other people at the time. Another person needed to be monitored regularly however due to staff being busy this did not happen on the day of our inspection. The lack of staff at mealtimes meant that people were often left waiting for their food. We saw several occasions when this happened.

Staff told us that staffing levels had improved. One staff member said, "It's better than it was but we have a lot of agency staff working now". Another member of staff said "It's difficult sometimes because we have people with challenging behaviours and they need a lot of attention". The registered manager told us that during the day there should have been two nurses and nine or 10 care staff on duty throughout the day to support the needs of 49 people. On the day of inspection there was less than the required number of staff on duty as there was one nurse and eight care staff in the morning and six care staff in the afternoon. At night there should be one nurse and three care staff.

We checked the staffing rotas for a four week period and found that there were less than the required number of staff on duty every day including at weekends and at night, this included nursing staff. The registered manager had not used agency staff to meet the shortfall. There were only two nursing staff on duty for three days of the week and on other days only one nurse was working. The registered manager told us that they had difficulty in recruiting qualified nursing staff. They also told us they had introduced an additional shift to support people at meal times and when they wanted to go to bed however this only happened four times a week. The registered manager said that they were trying to recruit additional staff to ensure this shift was covered every day.

There were not always enough staff deployed to meet people's needs. This is a continued breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Safe recruitment practices were in place for permanent staff. Staff recruitment records contained the necessary information to help ensure the provider employed staff who were suitable to work at the home. We saw staff had Disclosure and Barring Service checks to identify if they had a criminal record. Application forms had been fully completed with any gaps in employment explained. There were also copies of other

relevant documentation including references, job descriptions and interview notes in staff files. Where agency staff were recruited there were occasions when the provider did not ensure that the necessary competency checks and other relevant information had been provided. The registered manager told us that they no longer used this agency.

Risks to people's health were not always managed consistently. Where people had an identified risk this was not always updated in peoples care plans so staff might not always be aware of what they should do. One person was being cared for in bed and was at high risk of developing pressure sores, the risk assessment did not reflect the change to the care that was to be provided which meant that staff, particularly agency staff, would not know what action to take to minimise this risk. Where people had been identified as being at risk of falling action had not been taken to minimise to reduce the likelihood of this happening again. For other people risk were managed appropriately, one person who was at risk of choking which had been identified and action taken to address this by referring them to the Speech and Language Therapy Team.

Whilst accidents and incidents had been recorded appropriately there was no analysis completed to identify trends or patterns that might reduce the risk of this happening again. Nursing staff told us that they would make a record of the incident and the pass this to the registered manager to look into however this had not happened in the incidents we viewed.

People were at risk of receiving unsafe care or treatment. This is a breach of Regulation 12 of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014

Medicine administration records (MAR) and other medicines management records were not always up to date. Several MAR's had missing photographs of people, which could lead to staff not being able to identify the correct person they were giving medicines to. People who used 'as required' (PRN) medicines did not have protocols in place for each 'as required' medicine. These protocols are a safety mechanism to guide staff to when and how often these medicines should be given before advice from the GP is needed.

There was no evidence of stock medicines being checked or counted. There was not an observed system in place to record when people did not want to take their prescribed medicines and why. This could lead to staff not having oversight of a person change in health needs.

It is recommended that nursing staff review their competencies in relation to best practice guidance for PRN medicines and the accurate recording of medicine stocks.

People received their medicines as prescribed and staff followed current guidance in relation to the management of medicines accept for PRN (as required medicines). We saw staff give people their medicines after checking the information contained in their medicines administration record (MAR). A nurse was responsible for the medicines being given to people and was observed carrying out the task. The nurse commented that 'the MAR system is easy to follow'

Staff had received training in relation to safeguarding within the last year and were able to describe what they would do if they suspected abuse. They were aware that a referral to the local authority safeguarding team should be made in line with the provider's policy. Staff knew who to speak to if they had a concern about the care or treatment provided to people. One staff member told us, "I would go to one of the nurses or the manager if necessary". Another staff member said, "I would let you (the Care Quality Commission) know if the manager didn't deal with it." Staff confirmed to us the registered manager operated an 'open door' policy and that they felt able to share any concerns they may have in confidence. The registered

manager had appropriately referred concerns to the local authority.

During our last inspection we found the premises were not always kept clean or properly maintained. During this inspection we found that improvements had been made and there was a programme of refurbishment in place. New flooring had been laid in some areas of the home and decorating had been undertaken.

Staff told us they had received appropriate infection control training and we saw them wearing protective clothing and removing gloves when leaving a room. We spoke to a member of the housekeeping team who spoke knowledgeably about their COSHH (Control of substances hazardous to Health) training and their cleaning schedule. Bathroom areas, with one exception were clean and had recently been refurbished. Hand sanitising gels were placed at strategic points throughout the home to prevent the spread of healthcare related infections and we saw staff use these throughout the day.

Requires Improvement

Is the service effective?

Our findings

People told us they were supported by staff who had access to a range of training to develop the skills and knowledge they needed to meet their needs. One person said "Happy here, staff support me and take care with the things that I need to be doing." A relative told us "Very happy sure that they (staff) know what they are doing."

Staff told us the training they received was "Good" and was sufficient and appropriate to enable them to carry out their duties. However we saw several examples where staff displayed poor manual handling techniques that put people at risk of harm. Staff told us that they had received up to date manual handling training but this was not always put into practice when they supported people to move. One person was pulled backwards in their wheelchair with their feet dragging along the floor without the foot rests being used risking an injury them. On other occasions staff were assisting people to stand up by pulling them up rather than using a manual handling belt. When asked about the use of the manual handling belt staff did not understand what this meant. We saw a staff member assist a person transfer from a wheelchair by initially staff attempting to lift the person without the brakes being on. Eventually they used a hoist however were unsure how to use it.

As not all staff were suitably trained in relation to effective manual handling this is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Staff told us the training they received was good and it was sufficient and appropriate to enable them to carry out their duties. We spoke with staff about their experiences of induction following the commencement of employment. One staff member told us, "I was new to this kind of work and to the country when I started. The induction was really good. I shadowed staff until I felt okay and had lots of help." The registered manager told us that "The qualified staff who were due to undertake revalidation, will be starting in May."

Another staff member told us they had recently had medicines training and dementia awareness, but had not had any other specific training related to the types of conditions people may be living with in the home. Supervision and appraisal records detailed that supervision sessions and yearly staff appraisals for all staff had been undertaken regularly in 2015.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When people lack mental capacity to take particular decisions, any decisions made on their behalf must be in their best interests and as least restrictive as possible.

Not everyone who lived at the home had capacity to make decisions about the care and treatment they received. There were not suitable arrangements in place to ensure that staff obtained consent from people in relation to the care and treatment they received. A number of people who lived at the home were living

with dementia. There had not been any mental capacity assessments completed by the registered manager which meant that people were at risk of receiving care that was not always in their best interests. Where peoples consent should be obtained about specific decisions such as the use of bed rails, this had not always been sought.

Most of the staff we spoke with had undertaken recent MCA training and had an understanding of the implications of the MCA, including the nature and types of consent, people's right to take risks and the necessity to act in people's best interests when required.

As the requirements of the MCA had not been followed this is a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA however as there had not been any mental capacity assessments completed we were unable to confirm whether there had been appropriate referrals made to the local authority in all cases. Two people had been referred to the local authority, these had mental capacity assessments completed but no reason had been given for the referral for DoLS authorisation.

At our previous inspection in June 2015 we found breaches of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We found at this inspection that improvements had been made to support people to have enough to eat.

People said "I really like the food here. They know that I like finger food for supper and they bring me snacks when I ask." Another person said "'I have a cup of tea and they give me a cooked meal and look after me when I come in."

People were supported to have enough to eat. However the dining experience for people was variable depending on where they ate and who supported them. We observed that snacks and hot drinks were provided at specific times during the day and people told us that if they wanted a snack then staff usually got them what they wanted.

People who chose to stay in their rooms were supported to eat. We saw that two people were supported appropriately by staff who spoke reassuringly to them and waited before offering another spoonful of food and asked if the people if they wanted any more.

Staff we spoke with told us a menu was prepared by the chef and registered manager. Staff told us the people were advised of the day's meal. If they did not want this meal then an option of omelette or sandwich was provided instead.

Risks to people with complex nutritional needs were identified. Staff ensured they told the chef of people who required a soft diet, for example, or those who could not eat certain foods. The information was contained on a board in the kitchen and updated regularly by staff. People who required it had access to dietary and nutritional specialists who provided guidance for staff to follow. For example, we saw one person had been referred to the dietician. Staff told us of the importance of recording what people ate and drank and why it was necessary to weigh people regularly. Where people were at risk of malnutrition they

were weighed regularly and actions taken to address this.

Staff ensured people's daily health needs were met and that people had access to external health care professionals. Staff told us the GP came to the home once a week to review people who were not well, or whose health needs had changed. We were told by a healthcare professional staff referred people appropriately and in a timely manner to the GP surgery. We read in people's care plan they had involvement from the GP, district nurse, chiropodist, speech and language therapy team. One person had lost weight and we read staff had referred them to the dietician. One person said "They always get a doctor in if I feel ill.

People told us they were supported by staff who had access to a range of training to develop the skills and knowledge they needed to meet their needs. One person said "Happy here, staff support me and take care with the things that I need to be doing." A relative told us "Very happy sure that they (staff) know what they are doing."

Staff told us the training they received was "Good" and was sufficient and appropriate to enable them to carry out their duties. However we saw several examples where staff displayed poor manual handling techniques that put people at risk of harm. Staff told us that they had received up to date manual handling training but this was not always put into practice when they supported people to move. One person was pulled backwards in their wheelchair with their feet dragging along the floor without the foot rests being used risking an injury them. On other occasions staff were assisting people to stand up by pulling them up rather than using a manual handling belt. When asked about the use of the manual handling belt staff did not understand what this meant. We saw a staff member assist a person transfer from a wheelchair by initially staff attempting to lift the person without the brakes being on. Eventually they used a hoist however were unsure how to use it.

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The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When people lack mental capacity to take particular decisions, any decisions made on their behalf must be in their best interests and as least restrictive as possible.

Not everyone who lived at the home had capacity to make decisions about the care and treatment they received. There were not suitable arrangements in place to ensure that staff obtained consent from people in relation to the care and treatment they received. A number of people who lived at the home were living with dementia. There had not been any mental capacity assessments completed by the registered manager which meant that people were at risk of receiving care that was not always in their best interests. Where peoples consent should be obtained about specific decisions such as the use of bed rails, this had not always been sought.

Most of the staff we spoke with had undertaken recent MCA training and had an understanding of the implications of the MCA, including the nature and types of consent, people's right to take risks and the necessity to act in people's best interests when required.

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Requires Improvement

Is the service caring?

Our findings

At our inspection in June 2015 there was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We found at this inspection that the registered provider and registered manager had not made the improvements required to support people's dignity.

People told us the care staff were kind. One person said "Very good people looking after me. Very good kind people" Another person said "I am very well looked after here. They take good care of us." A relative told us "The youngsters are all so good to my relative. They enjoy it when they sit and chat to him. They are all very kind".

Although people and relatives made these comments our observations during the inspection did not support these statements. People were not always treated with consideration or dignity by some staff. On occasions staff either ignored people who were agitated or did not respond appropriately to certain incidents. One person repeatedly walked around the home and kept saying they wanted to go home. Staff did not engage with this person who became increasingly agitated as a result. During the morning we saw staff give a person a drink and state loudly to them "Drink your drink, but don't throw it like you do sometimes." We saw another person ask for a drink and staff responded "Wait until 3 o'clock."

At lunch time one member of staff said "Who else needs feeding?" loudly across the dining room whilst another spoke sharply to a person who was living with dementia that was becoming agitated and was asking where they were. There were little meaningful interactions between people and staff at the start of lunch.

People who stayed in their rooms were at risk of becoming socially isolated. At times it was difficult to find staff on the upper floor. One person said "I'm always on my own."

People's dignity was not always respected by staff. This is a continued breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Some staff knew what 'person centred care' was. One staff member said "I like getting involved with the residents, it helps me with looking after them and gives me a chance to talk to them about their past." Another staff said; "Each aspect of each person's life is different. We have that in mind."

People could make some of their own decisions about the care they received. We heard from people how they could get up or go to bed when they wished and those who preferred to eat lunch in their own room were provided with this.

People told us their views were not always sought on care plans and risk assessments and they were not always given opportunities to alter the care plans if they needed to.

People told us they could return to their rooms and have time on their own if they wished it. One person told

us they liked to spend time in their room. We saw people meeting with their relatives and moving to other areas of the home in order to have time alone.

Visitors were made to feel welcome. It was evident relatives where welcomed into the home and could call unannounced. We heard relatives talk to people and staff in a relaxed and friendly manner. One relative said; "Last Christmas was going to be my first on my own so they put me up in a room so I could spend Christmas with my relative. All so nice to us."

Requires Improvement

Is the service responsive?

Our findings

People told us that there were not many social activities to take part in. One person told us; "Not really enough to do. Would like more things to do." Another person said; "There's not a lot going on. A bit boring actually."

People were not always supported to follow their interests and take part in social activities. Although the registered manager had arranged for entertainers to come to the home such as music groups there was a lack of stimulation for people. We did not observe any specific activities suitable for people living with dementia and staff were not able to give us examples of appropriate activities. There was a lot of pictorial memorabilia around the home such as photographs, pictures, paintings on the walls, but nothing sensory that people could pick and touch.

People were sitting during the morning whilst staff were carrying out duties without any interaction. There were periods when no staff were present in lounge areas and there was a television in the dining room which was playing with no-one watching it. People were sometimes socially isolated as staff did not have time to spend with them. One person said "I stay in this room all the time, I'd like to get out." Another person said "I would love to know more about personal computers." However they had not been supported to develop this interest.

We observed during the morning people sitting in lounge areas with the television on, but no other stimulation. There was no information about daily activities provided for people, the registered manager told us the activities person had left and they were in the process of recruiting another.

People did not have care plans that clearly explained how they would like to receive their care, treatment and support. The care plans we looked at contained no life histories or social assessments. They did not contain information that staff could use to help build relationships, for example, people's previous occupations and hobbies. Consequently, it was not possible to 'see the person' in the care plans. People that had specific illnesses such as Parkinson's or diabetes did not have care plans that reflected these needs. Agency staff said that they had not read the care plans to get to know people when they first started. This meant staff may not fully know the needs of the person and the right way to provide care.

One person had been admitted to the home following a hospital stay and had been advised not to weight bear for several months. They had not walked or exercised since their admission and had asked if they could do so. Staff we spoke with were unaware that the person could get out of bed.
Staff told us any changes to a person's needs were discussed during their handover meeting and also written in a communications book which all staff signed to say they had read.

People said they were not involved in the development of care plans or their reviews. One person said "I've never seen a care plan." There was evidence of reviews of care plans being completed. However the review stated no changes and did not accurately reflect a person's change in need. For example some people had had a chest infection and prescribed antibiotics and this information had not been reflected in the persons

review. Other people's health had deteriorated and as such their mobility had reduced which had also not been reflected in the person care plan reviews.

The registered manager had not actively sought people and relatives views in the running of the home. Residents meetings had not been held since the last inspection in June 2015. The registered manager told us they had been prioritising other areas of concern such as recruitment and staffing.

The lack of person centred planning is a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The complaints policy was displayed clearly in the service. People and relatives felt their complaints were responded to in a timely way. A relative told us they had complained. They said "There was a concern that cream was not being applied when it should have been. I mentioned it and action was taken at once to put things right." Another relative said; "I have only raised a few minor issues and they were dealt with rapidly." Staff told us if anyone raised a complaint they would notify the manager immediately.

Requires Improvement

Is the service well-led?

Our findings

People and relatives were generally happy with the service provided and the care they received.
People we spoke to knew the registered manager and said that she always had time for them. Relatives commented "The manager is very approachable and a nice person" and "The manager is very kind."

The registered provider and registered manager showed an understanding of the regulations that underpin providing safe, effective, responsive, caring quality care; however they had not ensured staff developed their own understanding and had not always prioritised the individual needs of people.
The registered manager told us "Oakhurst Court's philosophy is to provide a family friendly 'home from home' atmosphere and to treat each and every individual with respect, dignity and complete understanding." We asked staff about the vision and values of the home. One staff member said, "We try to make it a nice place to live". Another staff member told us, "I think it's about getting to know people."
We asked staff members if they thought the home was well led. One staff member said, "I think so yes. If I have a problem I can go to the manager." However not all staff felt that they were supported or listened to. Staff said they did not feel involved in the running of the home. One staff member said "I do not want to make any suggestions to the manager". They felt things would not change if they did. From looking at staff meeting minutes it was clear that previous issues were not always followed through. These meetings did not take place regularly which was a missed opportunity to seek suggestions from staff about how to improve the quality of the service. The support structures in place for the qualified staff did not include any external peer support or any processes for revalidation of their professional codes of conduct.

The registered manager did not have quality assurance systems and processes to assess, monitor and improve the quality and safety of the services.the last audits carried out for nutrition was in March 2015, Night visit chceks June 2015, care plans February 2015. Although there were some procedures and documents in place to assess the quality of the service and identify any areas of concern they had not undertaken the audit schedule in relation to care plans, mobility needs, MCA and DoLS. Audits recently undertaken were for medicines, and an external professional undertaook a food hygiene audit in January 2016 where they recommended the chef take a level three in food safety.

Quality assurance systems had not ensured that people were protected against some key risks as described in this report. For example, in relation to care plans reviews, and the Mental Capacity Act 2005. For example, if regular care plans audits had been undertaken they would have identified the lack of appropriate reviews and person centred care. Regular monitoring of staff practice in relation to activities would have identified that some people were not being supported to have 'quality' days. The registered manager told us they had not undertaken regular monitoring of the service.

The lack of robust monitoring systems was a breach in Regulation 17 the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

All the policies that we saw were appropriate for the type of service, reviewed annually, were up to date with legislation and fully accessible to staff. The staff knew where they could seek further guidance.

The registered manager had ensured consistently that the appropriate and timely notifications had been submitted to CQC when required and that all care records were kept securely throughout the home.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care The registered manager had not ensured people have care and treatment that is specifically personalised for them.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent The registered manager had not followed the principles of MCA and DoLS.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People were at risk of receiving unsafe care or treatment

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The registered manager did not have robust systems in place to assess and monitor the quality of the service provided.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There were not always enough staff deployed

Diagnostic and screening procedures

Treatment of disease, disorder or injury

to meet people's needs.

Not all staff were suitably trained in relation to effective manual handling