Care Quality Commission

Key inspection report

Care homes for older people

Name:	Oak House
Address:	54 St Leonards Road Devon EX2 4LS

The quality rating for this care home is:	two star good service

A quality rating is our assessment of how well a care home is meeting the needs of the people who use it. We give a quality rating following a full review of the service. We call this full review a 'key' inspection.

Lead inspector:	**Date:**							
Rachel Fleet	1	3	1	0	2	0	0	9

This is a review of quality of outcomes that people experience in this care home. We believe high quality care should

- Be safe
- Have the right outcomes, including clinical outcomes
- Be a good experience for the people that use it
- Help prevent illness, and promote healthy, independent living
- Be available to those who need it when they need it.

The first part of the review gives the overall quality rating for the care home:

- 3 stars - excellent
- 2 stars - good
- 1 star - adequate
- 0 star - poor

There is also a bar chart that gives a quick way of seeing the quality of care that the home provides under key areas that matter to people.

There is a summary of what we think this service does well, what they have improved on and, where it applies, what they need to do better. We use the national minimum standards to describe the outcomes that people should experience. National minimum standards are written by the Department of Health for each type of care service.

After the summary there is more detail about our findings. The following table explains what you will see under each outcome area.

Outcome area (for example Choice of home)

These are the outcomes that people staying in care homes should experience. They reflect the things that people have said are important to them:

This box tells you the outcomes that we will always inspect against when we do a key inspection.

This box tells you any additional outcomes that we may inspect against when we do a key inspection.

This is what people staying in this care home experience:

Judgement:

This box tells you our opinion of what we have looked at in this outcome area. We will say whether it is excellent, good, adequate or poor.

Evidence:

This box describes the information we used to come to our judgement.

We review the quality of the service against outcomes from the National Minimum Standards (NMS). Those standards are written by the Department of Health for each type of care service.

Copies of the National Minimum Standards – Care Homes for Older People can be found at www.dh.gov.uk or bought from The Stationery Office (TSO) PO Box 29, St Crispins, Duke Street, Norwich, NR3 1GN. Tel: 0870 600 5522. Online ordering from the Stationery Office is also available: www.tso.co.uk/bookshop

The mission of the Care Quality Commission is to make care better for people by:

- Regulating health and adult social care services to ensure quality and safety standards, drive improvement and stamp out bad practice
- Protecting the rights of people who use services, particularly the most vulnerable and those detained under the Mental Health Act 1983
- Providing accessible, trustworthy information on the quality of care and services so people can make better decisions about their care and so that commissioners and providers of services can improve services.
- Providing independent public accountability on how commissioners and providers of services are improving the quality of care and providing value for money.

Reader Information

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Information about the care home

Name of care home:	Oak House
Address:	54 St Leonards Road Devon EX2 4LS
Telephone number:	01392430005
Fax number:	01392428008
Email address:	info@oakhouseexeter.co.uk
Provider web address:	www.oakhouseexeter.co.uk

Name of registered provider(s):	Oak House (Exeter) Ltd
Name of registered manager (if applicable)	
Mrs Dianne Smyth	
Type of registration:	care home
Number of places registered:	10

Conditions of registration:		
Category(ies) :	Number of places (if applicable): Under 65	Over 65
dementia	10	0
mental disorder, excluding learning disability or dementia	10	0
old age, not falling within any other category	0	10

Additional conditions:
The maximum number of service users who can be accommodated is 10.
The registered person may provide the following category of service only: Care home only - Code PC, to service users of either gender whose primary care needs on admission to the home are within the following categories: Dementia - Code DE - maximum number of places:10, Mental Disorder, excluding learning disability or dementia - Code MD - maximum number of places:10, Old age, not falling within any other category - Code OP - maximum number of places:10.

Date of last inspection								

Brief description of the care home
Oak House is registered to provide care and accomodation for up to 10 people. Adults of any age can be admitted if their primary care needs are due to dementia, or mental

Brief description of the care home

disorder (excluding learning disability or dementia). The home may also admit people whose primary care needs are due to 'old age' and not falling within any other category. It cannot provide nursing care except through local community nursing services.

The home was previously part of the now adjacent Highlands Care Home. In April 2009, the Oak House section of Highlands was registered as a separate care home. Dr Tristram Smyth is the Responsible Individual on behalf of the registered provider/owner, Oak House (Exeter) Ltd., with Mrs Dianne Smyth being the Registered Manager.

It is in a residential area of Exeter, with local shops and a pub relatively near by. The front door is in the passage on the left side of the home. A small car park is at the front of the building, and a mature garden at the rear, accessed from a small conservatory.

There is a ground floor lounge and a lounge-diner, as well as the conservatory area. Bedrooms are for single occupancy, do not have en-suite facilities, and are on both floors of the home. They vary in size and outlook. Baths with adaptations for people with mobility problems are also sited on both floors. Access between the two floors is by stairs or chair lift. Staff have separate facilities for their breaks, etc.

At the time of this inspection, fees were £400-650 per week. These excluded: chiropody (£13), hairdressing (from £6.50), newspapers for individuals, toiletries, dry cleaning, and some costs incurred on outings - such as ticket prices, or Christmas meals on related outings. The home pays staff and petrol costs, as well as sundries such as drinks, on outings.

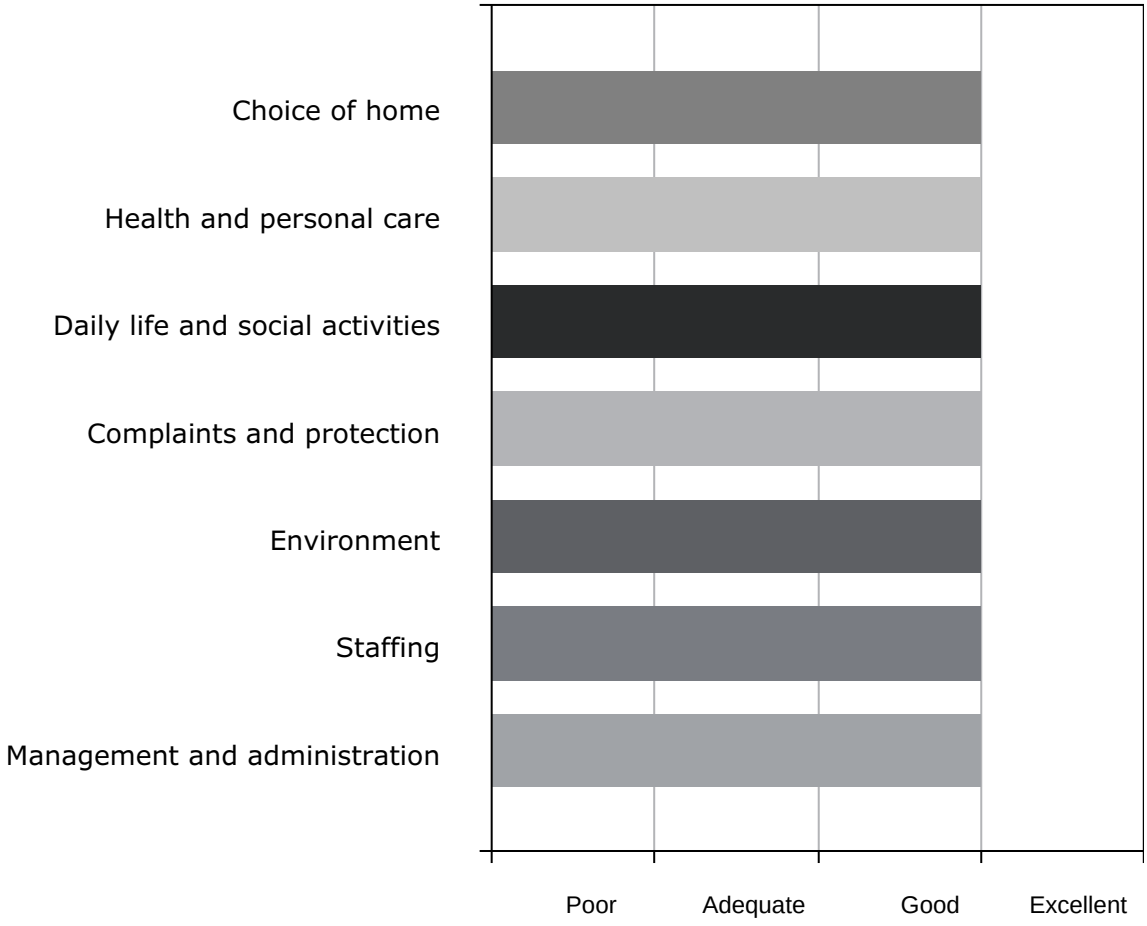
This is our first inspection of the home. Our inspection reports will be available from the manager, or through our website.

Summary

This is an overview of what we found during the inspection.

The quality rating for this care home is:	two star good service

Our judgement for each outcome:



How we did our inspection:

This key inspection took place as part of our usual inspection programme. It was the home's first inspection since its new registration in April 2009.

We carried out an unannounced visit to the home, as part of the inspection, which lasted 8 hours on a week day. It was carried out by Rachel Fleet and Louise Delacroix, regulation inspectors. The visit included time spent with the Responsible Individual and registered manager, Mrs Dianne Smyth, with who we also discussed our findings at the end of the day. She and her staff assisted us fully throughout the day.

Prior to this visit, the home had returned a questionnaire (the Annual Quality Assurance Assessment, or AQAA), about the service they offered and any plans for the future. This gave general information about people living at the home and the staff, some assessment of what the home does well, and any plans for improving the service.

Before our visit, we sent 10 surveys to the home for people who lived there, with 5 staff surveys. We also sent surveys to 5 health care professionals who supported various people living at the home. Surveys were returned from 7 people living at the home (5 of who were helped by their families to complete them), from 3 staff and 1 professional. Surveys were positive about the home. One person opted on their survey to speak to us, so we met with them during our visit.

There were 10 people living at the home. We spoke in more depth with 3 of them, and chatted with others as we spent time around the home. Some people could not give us their views because of communication difficulties caused by dementia. Because of this, we spent some time in communal areas to help us get a sense of people's well-being, how they were able to use their environment, and how staff supported them.

We 'case-tracked' 3 people living at the home. They included men and women, privately funded people and those funded by Social Services, people new to the home, and people with greater needs than others at the home. 'Case-tracking' involved looking into these people's care in more detail by meeting them, checking their care records and related documentation, talking with staff about their care, and observation of care or support these people received.

We spoke with 4 care staff and looked at various records, including those relating to staff, health and safety, and quality assurance. Our tour of the building included the kitchen and laundry, as well as people's bedrooms and shared areas.

Information from these sources, and from communication with or about the service since its registration, is included in this report.

What the care home does well:

Prospective residents and their families have the information to make a decision about whether they move to the home. This and the home's thorough needs assessment process ensures the success of any eventual admissions to the home.

People can have confidence in the care home because it is led and managed appropriately. The home's procedures and practises help to ensure people's concerns are heard, and that they are protected from harm - for example, the home's recruitment procedures protects them from unsuitable staff.

People have safe, appropriate support as there are enough competent staff on duty at all times. Staff are caring in their approach and generally respect people's dignity.

The home strives to meet people's diverse emotional and social needs. They benefit from ongoing links with the community around the home, including their family and friends. They have nutritious, attractive meals and snacks, eaten in congenial settings. Their accommodation is generally well maintained, homely and clean.

What has improved since the last inspection?

This was our first inspection of Oak House.

What they could do better:

Although people's various needs are currently met, further person-centred care planning and attention to an aspect of medication management would help to ensure that people's personal and health needs will be met in an individualised, consistent and safe way in the longer term. People would also benefit if staff had further training and development related to the needs of those living at the home.

Some additional actions would further demonstrate that the home is run in the best interests of everyone who lives there. For example, monitoring heating and lighting in people's bedrooms, providing radiator covers throughout the home to minimise the risk of burns, and establishing record-keeping in relation to any items kept by the home on behalf of individuals.

It was positive to find that staff were clear about their responsibility to report on poor or abusive practise and knew reporting procedures within the home. A more robust safeguarding policy and greater staff knowledge of local reporting procedures would offer people greater protection from abuse. Notifying us of certain events or incidents at the home would help to evidence that the home manages such occurrences appropriately.

If you want to know what action the person responsible for this care home is taking following this report, you can contact them using the details on page 4.

The report of this inspection is available from our website www.cqc.org.uk.

You can get printed copies from enquiries@cqc.org.uk or by telephoning our

order line 0870 240 7535.

Details of our findings

Contents

Choice of home

These are the outcomes that people staying in care homes should experience. They reflect the things that people have said are important to them:

People are confident that the care home can support them. This is because there is an accurate assessment of their needs that they, or people close to them, have been involved in. This tells the home all about them and the support they need. People who stay at the home only for intermediate care, have a clear assessment that includes a plan on what they hope for and want to achieve when they return home.

People can decide whether the care home can meet their support and accommodation needs. This is because they, or people close to them, have been able to visit the home and have got full, clear, accurate and up to date information about the home. If they decide to stay in the home they know about their rights and responsibilities because there is an easy to understand contract or statement of terms and conditions between them and the care home that includes how much they will pay and what the home provides for the money.

This is what people staying in this care home experience:

Judgement:

People using this service experience **good** quality outcomes in this area. We have made this judgement using a range of evidence, including a visit to this service.

Prospective residents and their families have the information to make a decision about whether they move to the home, which with the thorough assessment process ensures the success of any eventual admissions to the home.

Evidence:

The home had comprehensive printed information about its facilities and the service it offers. Mrs Smyth confirmed this information can be provided in large print on request, and told us that information is also available from the home's website.

Surveys returned by people living at the home or their representative all confirmed that they received enough information to help them decide if the home was the right place for them. All said they had written information about the home's terms and conditions.

We looked at the care records for someone who was staying at the home on a respite

Evidence:

stay. The manager told us that they had visited the person prior to them moving to the home, and had liaised with the community psychiatric nurse about their care needs. They also confirmed that the person had visited the home prior to their move. In another case, we saw the manager had obtained detailed information from the person's next of kin and their previous GP.

A survey from a health professional indicated they thought the home's assessment arrangements usually ensured that accurate information was gathered and the right service planned for the individual. Staff felt they had sufficient and appropriate care-related information about people who were due to move into the home. They told us this came from the manager's assessment and questionnaires completed by the person's family about their personal history, which we had seen in people's care records.

Health and personal care

These are the outcomes that people staying in care homes should experience. They reflect the things that people have said are important to them:

People's health, personal and social care needs are met. The home has a plan of care that the person, or someone close to them, has been involved in making. If they take medicine, they manage it themselves if they can. If they cannot manage their medicine, the care home supports them with it, in a safe way. People's right to privacy is respected and the support they get from staff is given in a way that maintains their dignity.
If people are approaching the end of their life, the care home will respect their choices and help them feel comfortable and secure. They, and people close to them, are reassured that their death will be handled with sensitivity, dignity and respect, and take account of their spiritual and cultural wishes.

This is what people staying in this care home experience:

Judgement:

People using this service experience **good** quality outcomes in this area. We have made this judgement using a range of evidence, including a visit to this service.

Staff are caring in their approach and generally respect people's dignity. Although people's needs are currently met, aspects of care planning and medication practises create a risk that people's needs may not be met in an individualised, consistent and safe way in the longer term.

Evidence:

Of surveys from people who lived at the home - when asked if they received the care they needed - 2 said they usually did, with 5 saying they always did. They all felt that staff were available when they needed them, and that the home ensured they received the medical help they needed. Three of the surveys included comments from relatives specifically on the care provided by the home, all being positive. 'My relative is very well cared for', and 'They take individual needs seriously,' for example.

A health professional surveyed thought peoples' needs were always properly monitored, reviewed and met by the service, with the home always seeking advice and acting on it in order to meet people's needs.

Evidence:

We saw that a behaviour assessment chart had been recently started, regarding one person living at the home. This was a record of behaviour rather than advice for staff on how to respond. Staff said that care plans do not always provide this form of guidance, and they were not sure how they should respond when one person we case-tracked had hallucinations as indicated in their care records, for example.

A care plan we looked at contained risk assessments relating to aspects of an individual's health, but did not give a clear sense of who the person was, and their daily routine. There was also a lack of cross-referencing, with the care plan stating that the person needed liquid medication but without indicating elsewhere if it had been considered if they had any swallowing difficulties with meals or drinks, for example. However, for another person, we saw that specialist advice had been sought regarding potential swallowing difficulties.

A person we met during the inspection told us that they were warm and comfortable, and showed us the pressure relieving cushion that they were sitting on. They told us that their pain was well managed, and we heard staff checking with them about their pain levels. They said that they walked with a frame, and that this was available when they needed it.

We met another person who was very frail and who was provided with specialist skin care equipment to keep them comfortable and safe. Staff were clear in discussion about what the risks might be for them, and why this type of care was needed. The equipment was at the correct setting for the individual's weight.

We saw that people were provided with the specialist utensils described in their care plans to help them eat their meals. Staff we spoke with understood well about the use of the thickeners that they added to the drinks of someone with swallowing difficulties. There were clear guidelines in the person's care records on the matter. We noted staff had begun to monitor someone's intake when they began to refuse food. People's weights were recorded regularly also.

Someone we spoke with told us the district nurse visited them regularly regarding a health need they had. They also said they would be having their flu jab soon. They felt staff were attentive about people's health needs, and would call the GP if necessary. This was reflected in the care records we read. We saw that staff had taken action to ensure someone's hearing impairment was reviewed by appropriate professionals.

The manager told us how they been liaising with the Speech and Language Team for one person, and we saw why this was necessary during the inspection. They told us

Evidence:

that they felt well supported by the health professionals involved to meet this person's needs, which they recognised were complex. The home has recognised the person's changing needs and the impact this had on staff time, which staff confirmed but who also recognised that this high level of support was part of end of life care.

People we asked about their medication, and a health professional, were satisfied with how the staff dealt with it on their behalf. Staff we asked described appropriate procedures for the medicine rounds they carried out. Handwritten entries on people's medication sheets had been signed by 2 staff to verify their accuracy. Where one person's chart showed their medication had been increased, we saw this had been reflected in their care records also, which is very good practise. Where skin creams were prescribed, there was usually - but not always - guidance as to where the cream should be applied. The manager said she would monitor this to ensure good levels of information were maintained.

We noted that one person's care plan said that their medication should be crushed (so they could swallow it), but that this was not included in the directions from the prescribing GP, on the person's medication sheet. Staff did not know if advice had been sought from a pharmacist on helping this person take medication they needed, to confirm it was safe to crush the medication or to see if medication was manufactured in a more suitable form, etc. The manager said she would follow this up, and has since confirmed that a pharmacist has been consulted and directions from the GP have been updated.

There were no controlled drugs in use at the time of our visit, although one item was being recorded in the controlled drug register in accordance with good practise recommendations. This medication had not been dated on opening, so staff could not reliably know its shelf-life (as indicated by the manufacturer) thereafter.

One prescribed skin cream needing cool storage was kept in a fridge. Since containers of drinks were also stored in this fridge, the manager agreed that medications would be put in a container within the fridge, to minimise cross-infection risks. Daily temperature records had been made. We discussed it would be prudent also to record minimum/maximum temperatures.

A health professional felt staff always respected people's privacy and dignity. Staff training records showed that 'dignity and respect' is a topic included in the training programme. Communal toilets and bathrooms have locks that work, and we saw that people have the option for locking their doors. One person who used a key for their room thought all bedrooms required the same key, but Mrs Smyth assured us this was

Evidence:

not the case. The person was otherwise very satisfied with the level of respect for their privacy at the home.

During lunch, two staff members assisting people with their meals stood whilst doing this; one did not check that the person had finished eating before they gave the next spoonful. This is not best practise, as there is no eye contact and a lack of equality in the exchange. A visitor, when asked what the home could do better, indicated some staff were better than others at sitting down to converse with people about the individual's interests, both to build a relationship with the person and to avoid giving a wrong impression of standing over them.

Daily life and social activities

These are the outcomes that people staying in care homes should experience. They reflect the things that people have said are important to them:

Each person is treated as an individual and the care home is responsive to his or her race, culture, religion, age, disability, gender and sexual orientation. They are part of their local community. The care home supports people to follow personal interests and activities. People are able to keep in touch with family, friends and representatives. They are as independent as they can be, lead their chosen lifestyle and have the opportunity to make the most of their abilities. People have nutritious and attractive meals and snacks, at a time and place to suit them.
There are no additional outcomes.

This is what people staying in this care home experience:

Judgement:

People using this service experience **good** quality outcomes in this area. We have made this judgement using a range of evidence, including a visit to this service.

The home strives to meet people's diverse emotional and social needs. They benefit from ongoing links with the community around the home, including their family and friends. They have nutritious, attractive meals and snacks, eaten in congenial settings.

Evidence:

The AQAA said the home tries to adjust its activity programme as people's social needs vary or change. One person told us that they enjoyed reading the newspaper at the dining room table - as they were when we met them - and that it was the newspaper that they preferred to read. Later, we saw two people playing draughts with a volunteer member of staff, one of who had told us when we first arrived that this was a game that they enjoyed. We read that flower-arranging was listed as an interest for someone we case-tracked, and we saw that flower-arranging took place as part of the activity programme. We also noted that a group of school children regularly visit the home to entertain the residents by playing musical instruments. One person had indicated on their survey that more 'live music' would be welcomed.

Whilst spending time in the communal areas of the home, we saw that generally people looked relaxed although there was little conversation between staff and the people sitting there, apart from during an exercise session. Activities records showed

Evidence:

that people have regular access to gentle exercise with staff, specialist exercise sessions, drama therapy and aromatherapy.

We noted from the activity programme on a notice board that trips to the local quay, library, exhibitions, etc. were planned for one day a week. When telling us about the home, someone commented in their survey that they 'like going out on visits'. Another person, however, when asked what the home could do better, said not all activities seemed to happen, such as trips out. One person said they got bored, although they couldn't initially suggest what they would like to do; it appeared from their care records that - as the person told us - they went on outings with visitors, which they enjoyed, but that they were not taken out by staff at other times. We saw that some people visited local resources with staff, such as a nearby cafe. During our visit, a member of care staff accompanied someone who lived at the home to the funeral of a friend.

The manager told us the home is working to improve its record-keeping regarding activities, which will help to ensure people are given equal opportunities for various types of recreation, as well as enabling monitoring as to whether planned activities actually take place.

One person told us that they listened to religious music, but did not wish to be visited by anyone from the church. During our visit, the volunteer put on such music, talking briefly with this person about it. We saw from records that several people were supported to regularly attend church or a religious service. One person told us that the home paid their taxi fare, enabling them to attend a church in Exeter.

The home's Statement of Purpose indicated that there were no set visiting times. A relative commented on a survey 'Staff are most tactful and good-humoured, and extremely helpful (and pro-active) to relatives and visitors.' This was reflected by others. Another said 'I am kept fully informed of my relative's condition at all times, even when I am working abroad.' A person living at the home told us that visitors were encouraged. We saw that someone who visited during our inspection was welcomed by staff, who made sure that they were comfortable while they waited for the person they had come to see.

A health professional felt the home always supported people to live the life they chose, wherever possible. During the day, we saw people making day to day choices, such as where they sat, who they sat with and which room they spent time in. A person's care plan recorded their times of getting up and going to bed, which generally reflected their stated preferred times. People were offered a choice of drink, and when a person

Evidence:

asked for a different pudding, staff ensured that this was provided. Staff told us that one person preferred not to mix and needed personal space, and we saw that this was respected by staff. Staff told us that they knew people's personal preferences but that they always still offer a choice, which we also saw. However, a care plan we looked at did not detail the person's likes and dislikes.

Food was plated before it was served to people. Relatively small plates were used, intended to prevent people being put off their food by seeing a large meal, but we noted the plates were then piled high with food. This resulted in one person spending much of their meal returning their food to their plate as it kept falling off. One person commented they had been given too much. We discussed with the manager whether people could be given the option to serve themselves, enabling them to choose the amount of vegetables they had, for example.

The week's menu showed a variety of dishes at lunch and tea, with the main meal served at lunchtime. During our visit, the lunch was beef goulash, fresh broccoli and potatoes, with bannoffee pie for dessert. It was served in a calm and unrushed manner by staff, although there was little conversation. Most people ate in the lounge-dining room.

Prior to the meal, one person told us that the food was good, and during the meal another person said 'That was very nice'. Another person said that the beef had been 'tough' but that the pudding was 'nice' and made up for the main course. Orange juice was served except to one person; we saw their care records said they liked a different type of juice, which they were given instead.

We heard staff assisting someone with their lunch tell them what the meal was. They appropriately used a small spoon, so as not to create a risk that the person might choke because their mouth was too full. Other people were offered help discretely to cut up their food, or were given plate guards.

The home's Statement of Purpose indicated that alternatives to the meal of the day were available on request. A menu displayed in the home's entrance hall listed the meals that people could request if they wanted something different to the meal planned daily. Someone we asked about the food told us they didn't like mince so they were given a chop or a steak instead.

Kitchen menus showed that a light hot snack was available at teatime, with sandwiches offered later in the evening. We saw homemade cake was served mid-afternoon. A fruit bowl was available in a lounge. When someone helped themselves to

Evidence:

an orange, we saw the volunteer staff member offer to help them peel it, keeping the person company as they then ate it to ensure they managed it.

Complaints and protection

These are the outcomes that people staying in care homes should experience. They reflect the things that people have said are important to them:

If people have concerns with their care, they or people close to them know how to complain. Any concern is looked into and action taken to put things right. The care home safeguards people from abuse and neglect and takes action to follow up any allegations.
People's legal rights are protected, including being able to vote in elections.

This is what people staying in this care home experience:

Judgement:

People using this service experience **good** quality outcomes in this area. We have made this judgement using a range of evidence, including a visit to this service.

The home's procedures and practises help to ensure people's concerns are heard and that they are protected from harm, although they are not safeguarded as robustly as possible.

Evidence:

The complaints policy was clear and appropriately worded, with current contact details for external organisations. We saw it was included in the information provided about the home to prospective residents and other service users. A copy was displayed in the entrance hall just above the Visitors' book. This included the contact number for Care Direct (Devon County Council) and ourselves.

All surveys from people living at the home said there was someone they could speak to informally if they were not happy, and that they knew how to make a formal complaint. People we spoke with said they felt able to raise the matter with staff if something was wrong, one adding that Mrs Smyth always asked them how things were. A health professional surveyed said the service always responded appropriately if they or anyone else using the service raised any concerns. Surveys from staff indicated they all knew what to do if someone had concerns about the home.

Mrs Smyth told us she had not received any complaints, so there was no 'complaints log' yet. She said that if staff received a verbal complaint and she was not immediately available, they would leave the details in writing for her. We have not

Evidence:

received any complaints about the home.

We saw from minutes of a recent staff meeting that various matters with potential safeguarding implications had been discussed - ensuring people had choice, abuse and who to report it to, the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. Training records showed that 5 staff had had training on safeguarding a month prior to our visit.

Staff that we spoke to knew about their responsibility to report on poor or abusive practise, were clear about their roles within the home and who they would tell. However, they were less clear about the range of external services they should contact, if necessary - primarily, the police or Care Direct. The home's safeguarding policy did not provide this level of detail. Nor was it robust in its approach as it stated that an implicated member of staff can be employed in a non care role until further instruction, and did not refer to consulting the local safeguarding team.

One person we spoke with had jewellery and other possessions, but we did not see any inventories in their care records. It might be helpful to keep such records, especially if people have a degree of confusion or memory-loss. A record of people's own furniture is also required by regulation.

Use of bed-rails and alarm mats - which can adversely affect people's freedom of movement - were noted in some people's care records, as is good practise. For one person, we saw the bed-rails were being used only after a specific event, showing a considered approach to their use in general. It was not always stated what other options had been considered and rejected, for keeping individuals safe. However, we saw a particularly good risk assessment, which gave clear reasons as to why such a device was being used, with additional strategies staff were to use to protect the person welfare.

Environment

These are the outcomes that people staying in care homes should experience. They reflect the things that people have said are important to them:

People stay in a safe and well-maintained home that is homely, clean, pleasant and hygienic.
People stay in a home that has enough space and facilities for them to lead the life they choose and to meet their needs. The home makes sure they have the right specialist equipment that encourages and promotes their independence. Their room feels like their own, it is comfortable and they feel safe when they use it.

This is what people staying in this care home experience:

Judgement:

People using this service experience **good** quality outcomes in this area. We have made this judgement using a range of evidence, including a visit to this service.

People benefit from having accommodation that is generally well maintained, homely and clean.

Evidence:

Comments on surveys for people living at the home included 'Home spotlessly clean', and 'Loves own room with view of garden.'

On the day of our visit, the home had a comfortable, homely appearance, with settees provided in lounges and a choice of areas to sit in, for example. People told us where they liked to sit, and that their chairs were comfortable. The dining chair legs were on gliders, to help people get themselves to and from the dining tables more easily.

We saw people moving around the home throughout the day, some going in and out of their bedrooms. The home does not have a lift. Some people were able to use the stairs independently, and others were assisted to use the chair lift. Someone who used a walking aid independently said they got around the home without encountering any particular hazards or difficulties. Mrs Smyth said that one person had moved to a room on the ground floor when they had become physically frail and that their relatives, acting as advocates, had been involved in this decision

The home looked well maintained, with the AQAA confirming all servicing of facilities

Evidence:

was up to date. Someone pointed out their new bedroom carpet to us, telling us the owners had certainly 'spent money on the home'. One person told us they had had trouble with their television, but the handyman sorted it out. They also confirmed that they heard the fire alarm bells tested regularly, although hadn't been asked to take part in any fire drills yet.

We visited the garden, which was attractively maintained, and saw that it has been designed with two levels, including a level patio area complete with plants in pots. There was a selection of seats, and a good outlook.

We visited the majority of the rooms in the home, which were clean and odour free, despite some people's continence problems. People told us they liked their room, and we could see that people had individualised their rooms with pictures and furniture. Those we asked said there was plenty of hot water. Rooms have large windows and high ceilings, giving a sense of space. We noted ceiling lights were of relatively low wattage in some rooms (40-60W), one also having a dark uplighter shade, which Mrs Smyth said she would look into. However, staff told us that lighting in the lounges had been improved recently.

A couple of bedrooms we visited felt cool. One person said the heating wasn't on much yet, and another person who used their bedroom a lot confirmed they felt it was cold, when we spoke with them. There were no wall thermometers in place to assess this properly, although we have since been told that the home does have thermometers which can be used to check room temperatures.

We saw that staff had access to disposable gloves and liquid soap, although paper towels were not always available. They confirmed that they had received relevant training, and we saw them using hand washing facilities before handling food; they told us they were also supplied with disinfecting hand gel. People living at the home told us that staff wore gloves and aprons when helping them with personal care. They felt the home was kept sufficiently clean, including shared areas such as baths and toilets.

Laundry facilities included machines with appropriate programmes for thorough cleaning of washing; staff we asked knew what programmes to use. Specialist soluble bags were available for transporting and laundering of particularly soiled items.

Staffing

These are the outcomes that people staying in care homes should experience. They reflect the things that people have said are important to them:

People have safe and appropriate support as there are enough competent staff on duty at all times. They have confidence in the staff at the home because checks have been done to make sure that they are suitable to care for them. Their needs are met and they are cared for by staff who get the relevant training and support from their managers.
There are no additional outcomes.

This is what people staying in this care home experience:

Judgement:

People using this service experience **good** quality outcomes in this area. We have made this judgement using a range of evidence, including a visit to this service.

People have safe, appropriate support as there are enough competent staff on duty at all times. They are protected from unsuitable staff because of the home's robust recruitment procedures. They are cared for by staff who are given relevant training but who would benefit from further training related to the needs of the people living at the home.

Evidence:

Comments on surveys from people living at the home included that staff were patient, understanding, unrelenting, nothing was too much trouble, they were helpful, polite, and there was a high staffing ratio. One person said, 'The staff and manager are excellent'.

The 3 staff surveys indicated they felt there were always sufficient staff to meet people's individual needs. On the day of the inspection, there were three care staff on duty (which included a senior carer), plus a cook and the manager, looking after 10 people. A volunteer was also spending the day at the home to provide activities for people. An administrator is employed for 3 days a week.

Staff told us, and the manager confirmed that currently care staff also clean the room as part of their daily duties. We saw that rooms looked clean, and that people at the home also appeared appropriately supported in the morning. In the afternoon, two

Evidence:

care staff were on duty, with an additional staff member on Tuesdays and Thursdays to provide activities. We were told that there were two waking night staff on duty, which a person living at the home confirmed.

These staffing levels reflected the rota, apart from the manager, who was not on the rota. However, staff told us that even when the manager was not at the home that they could always contact her.

Several staff worked both day and night shifts, which helps to promote person-centred care. The AQAA told us that no agency staff had been used in the 3 previous months, promoting consistency of care for people. A health professional felt the manager and staff had the skills and experience to support people, and usually responded to the more diverse needs of individuals.

We looked to see how recruitment is managed at the home and how the people who live at the home are protected by the recruitment process. When the home opened, a number of staff transferred from the original home that that was owned by Mrs Smyth. We were told by Mrs Smyth and staff that since then one new staff member had been recruited. Their file showed that that the recruitment process contained appropriate safeguarding systems, such as identification, two written references and a police check. We also saw that the home ensures that police checks are obtained for volunteers, which is good practise.

Recruitment records we looked at included training certificates, such as for a recognised care qualification - showing that the staff member was suitably qualified for their post. The home uses an induction programme of a nationally recognised standard, with related training materials available for staff, although we could not look at the record for the new staff member because they kept it with them.

The AQAA stated that of the 10 care staff, 7 had a recognised care qualification or an equivalent. When we spoke to a member of staff, they told us they were undertaking an NVQ Level 3 and confirmed that they had received appropriate training for their role, including working with people with dementia and supporting people with diabetes. Another staff member told us that they had been provided with or been offered a range of suitable training; they felt that this equipped them to carry out their role, although they said they also learnt from watching other more experienced staff. Some staff are booked to undertake an accredited course on dementia, and on first aid. Information on the Mental Capacity Act 2005 was displayed on the staff notice board.

Evidence:

One person indicated that some staff were more mindful than others of the person's impaired sight - for example, leaving their personal possessions in their original place so the person could find them easily, or telling the person what was on their plate at mealtimes without being asked. Care plans for 2 people with hearing impairment guided staff to talk to them 'very loudly', which alone is not always sufficient or appropriate practise. Records did not show that staff had had recent training or updating on visual or hearing impairment.

Management and administration

These are the outcomes that people staying in care homes should experience. They reflect the things that people have said are important to them:

People have confidence in the care home because it is led and managed appropriately. People control their own money and choose how they spend it. If they or someone close to them cannot manage their money, it is managed by the care home in their best interests. The environment is safe for people and staff because appropriate health and safety practices are carried out.

People get the right support from the care home because the manager runs it appropriately with an open approach that makes them feel valued and respected. The people staying at the home are safeguarded because it follows clear financial and accounting procedures, keeps records appropriately and ensures their staff understand the way things should be done. They get the right care because the staff are supervised and supported by their managers.

This is what people staying in this care home experience:

Judgement:

People using this service experience **good** quality outcomes in this area. We have made this judgement using a range of evidence, including a visit to this service.

People can have confidence in the care home because it is led and managed appropriately, although some additional actions would further ensure it is run entirely in the best interests of everyone who lives there.

Evidence:

The home owner, Mrs Smyth, was recently registered as the manager for the home. She has many years of experience in owning and managing a care home for people with dementia. This was recognised in considering her application for the role, although she was still encouraged to undertake the recommended qualifications. Mrs Smyth said that she kept up to date with best practise through relevant journals, and had undertaken updating on diabetes and infection control matters. She has decided not to embark on any management qualification at present.

The relative of someone who lived at the home commented 'I have received kind & experienced support from Dianne Smyth and all the carers.' Staff told us that they felt well supported by the manager, who was available when they needed her. Records

Evidence:

showed that all staff, including the ancillary staff, received one-to-one supervision and had appraisals. Mrs Smyth told us that she worked during the week and visited the home at weekends, and that she was always contactable by phone. We saw a contact phone number for her clearly displayed in a staff area.

The home gives out surveys for quality assurance purposes. We saw some that had been completed by people's relatives or other visitors. Their views were sought on care, how people's social needs were met, communication, and the welcome that they received as visitors, among other things. Results were yet to be collated, for informing future development of the home and for feedback to people using the service.

Mrs. Smyth also felt that because Oak House is a small home and she is very available at the home, she sees people often enough to get their views on the service very regularly. We saw 'Thank you' cards from people's relatives on display. She doesn't seek the views of visiting professionals formally, seeing their recommendations to people about the home as evidence that they view it positively.

There was no-one living at the home who was subject to a deprivation of liberty authorisation, and we did not find that anyone was having their liberty deprived without an authorisation.

The AQAA indicated that everyone currently living at the home had a Power Of Attorney appointed or their family handled their finances. Mrs Smyth told us that the home does not hold personal allowances for people for minor expenditures. Instead, the home sends out itemised bills three-monthly, which are for expenses such as for hairdressing. The home was holding a sum of cash for someone, but had not provided the person with a receipt or kept any other records of it. Mrs Smyth said that she would ensure this was done in future.

A person living at the home told us that the bath had good safety features and was adapted so they could use it. We 'spot checked' the windows in three people's rooms and found that they were restricted to help prevent falls from a height.

Our tour of the building showed us that most radiators in people's rooms were covered, to help protect them from burns. Mrs Smyth told us that two rooms did not have protective covers but assured us that these had been ordered. In the meantime, a mattress protector was being used to offer some protection. Some radiators in communal areas were not covered; we were told this was because the risk was seen to be low, as these areas were staffed and that furniture acted as a barrier.

Evidence:

Accident forms showed there had been 12 accidents since the home was registered. Mrs Smyth said she audited them, although no written record was made of this yet. She told us that she had contacted the GP regarding someone for who more than one accident was recorded, after auditing these records, and was satisfied that there were no common themes or patterns (such as time of day, or place) to be acted on, regarding other people who had had falls.

Someone we spoke with did not have a call bell cable to enable them to summon help if they were sitting in their bedroom armchair. The person, who was relatively independent, said they didn't want one, and said that the night staff checked on them regularly at night to make sure they were alright.

We noted that we had not been informed of certain recorded incidents that had affected individuals living at the home. We asked that the manager notify us in future, as indicated by Regulation 37, which she said she would do.

Training records showed 3 staff had had training in safe handling the month before our visit, with others having training or updating within the last year. Staff we asked felt they had a safe working environment, with sufficient equipment, facilities and supplies to do the work they were expected to do.

The kitchen was clean and orderly, with cleaning schedules available and up to date, and specific hand-washing facilities. Records showed fridges were running at a temperature suitable for safe storage of food; leftovers or opened items in fridges were covered and dated. Mrs Smyth confirmed the home's cooks undertook the Environmental Health Department's food hygiene course, whilst a training DVD was used for all other staff.

Are there any outstanding requirements from the last inspection?				
	Yes	☐	No	☑

Outstanding statutory requirements

These are requirements that were set at the previous inspection, but have still not been met. They say what the registered person had to do to meet the Care Standards Act 2000, Care Homes Regulations 2001 and the National Minimum Standards.

No.	Standard	Regulation	Requirement	Timescale for action

Requirements and recommendations from this inspection:

Immediate requirements:

These are immediate requirements that were set on the day we visited this care home. The registered person had to meet these within 48 hours.

No.	Standard	Regulation	Requirement	Timescale for action

Statutory requirements

These requirements set out what the registered person must do to meet the Care Standards Act 2000, Care Homes Regulations 2001 and the National Minimum Standards. The registered person(s) must do this within the timescales we have set.

No.	Standard	Regulation	Requirement	Timescale for action
1	9	13	You must ensure that there are effective arrangements for the storage of medicines, especially that Effective systems are in place for following the manufacturer's guidance on the storage life of medicines So that people's medicines are managed safely, to meet their health needs.	10/12/2009
2	35	17	You must keep a record of all money or other valuables you receive for safekeeping on behalf of anyone living at the home, with reference to Standard 35 and as detailed in Schedule 4.9 (a)&(b) To protect the financial interests of people living at the home.	09/12/2009

Recommendations

These recommendations are taken from the best practice described in the National Minimum Standards and the registered person(s) should consider them as a way of improving their service.

No	Refer to Standard	Good Practice Recommendations
1	7	Care plans should be more person centred in their style to support staff in providing individualised care.
2	10	All staff should be mindful of their posture and body language - for example, sitting rather than standing when assisting people with a meal (enabling them to maintain eye contact and provide help at the person's pace), or when conversing with them.
3	18	It is recommended that a) All staff are familiar with the local authority's safeguarding procedures, especially the primary agencies in the community with safeguarding roles and responsibilities, to who they should report concerns if it becomes necessary, b) The home's safeguarding policy should promote a more robust approach to protecting people who live at the home from potentially unsuitable staff, as well as including consultation with the local authority's safeguarding team.
4	25	You should ensure individuals have sufficient heating and lighting in their bedrooms for their safety and comfort.
5	30	It is recommended that the staff training programme be revised regularly to ensure it includes conditions affecting people currently living at the home, or for whom the home is intended, such as visual and hearing impairment.
6	38	You should notify us of all events or incidents that adversely affect the well-being or safety of anyone living at the home.
7	38	All radiators should be covered properly, to provide greater protection from burns for people living at the home.

Helpline:

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Web: www.cqc.org.uk

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