Mr A D Sargeant

Oak House Residential Care Home

Inspection report

56 Surrenden Road
Brighton
East Sussex
BN1 6PS

Tel: 01273500785

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection took place on 3 January 2017 and was unannounced.

Oak House Residential Home is the only home owned by the provider. It provides accommodation for up to fourteen people living with dementia, learning disabilities and autistic spectrum conditions. On the day of the inspection there were ten people living at the home. The home is a large detached property spread over three floors with two communal lounges, a dining room and a garden.

We carried out an unannounced comprehensive inspection on 19 October 2015. Breaches of legal requirements were found and following the inspection the provider sent us an action plan outlining what they would do in relation to the concerns found. However, this action plan was not sent to us within the agreed timescales, and therefore the provider was in breach of regulation. At the previous inspection the current manager had been the deputy manager. At this inspection they had been in post as manager for 12 months and had started the process of applying to be registered manager. However, they had not taken reasonable steps to complete this process in a timely manner and the home had been without a registered manager for 12 months. Part of the provider's condition of registration states that a registered manager must be in place, therefore the provider was in breach of their registration. At this inspection, although some improvements had been made, there were continued and further breaches of legal requirements.

When asked if they felt safe, one person told us, "Definitely". However, risks assessments to assess peoples' safety had not always been completed and control measures to minimise risks in relation to health and safety had not always been implemented. Risks to people, who spent time in their rooms and who were unable to use call bells to summon assistance from staff, had not been assessed to ensure that there were suitable measures in place for staff to assure their safety and well-being. Personal emergency evacuation plans (PEEPS) that provided staff with guidance as to how to assist people to evacuate the building in the event of a fire were not in place for all people. Regular checks to ensure that emergency equipment, such as emergency lighting and fire alarms were working effectively had not taken place. Cleaning products were not stored securely and there was a potential risk, due to peoples' cognitive abilities, that they could have come into contact with these and caused themselves harm.

Staffing levels were not reviewed when there were changes in peoples' needs and therefore lacked the flexibility to ensure that there were sufficient staff to meet peoples' needs. The provider had ensured that they had made deprivation of liberty safeguard (DoLS) applications to the local authority for people who lacked capacity to access the community unsupported. However, they had not ensured that one of these was renewed when it expired. Records showed that several people had lost significant amounts of weight within a short period of time. This had not been recognised and therefore appropriate action had not been taken in response. Peoples' care plans had not always been reviewed and their records lacked detail. Staff were not always provided with the most up-to-date information to enable them to provide appropriate care.

Some people were able to maintain their independence by undertaking daily tasks such as dusting. External activities were provided for some people such as attending day services, however, for people who did not attend these there was a lack of meaningful activities and stimulation available and people spent most of their time watching television. A healthcare professional told us, "It is our belief that the home still needs to develop meaningful person-centred occupation for their residents with dementia. There are minimal dementia-specific resources available. The home is used by residents with learning disabilities who attend day centres and a possible consequence is that the home still needs support with understanding their role in delivering this aspect of care to their other residents".

There was a lack of quality assurance systems to enable the provider to have sufficient oversight and awareness of all of the systems and processes within the home. There had been no notifications sent to CQC. This is part of the provider's responsibilities. By not being informed of these incidents CQC were potentially unable to ensure that the appropriate actions had been taken to ensure that people were safe.

People were protected from harm and abuse. Staff were appropriately skilled and experienced and had undertaken the necessary training to enable them to recognise concerns and respond appropriately. People received their medicines on time and according to their preferences, from staff with the necessary training and who had their competence assessed. There were safe systems in place for the safe storage and disposal of medicines.

People were asked their consent before being supported. People and their relatives, if appropriate, were fully involved in the planning of care and were able to make their wishes and preferences known. Staff worked in accordance with peoples' wishes and people were treated with respect and dignity. It was apparent that staff knew peoples' needs and preferences well. Positive relationships had developed amongst people living at the home as well as with staff. Staff were caring and treated people with kindness and compassion. Peoples' health needs were assessed and met and they had access to medicines and healthcare professionals when required. People were made aware of their right to make comments or complaints about the care they received.

We found a number of 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 home was not consistently safe.

Risks associated with the safety of the environment and to ensure peoples' safety were not always assessed nor appropriate measures implemented. Several people had lost significant amounts of weight, this had not been recognised or appropriate action taken in response. Despite changes in the needs of people, staffing levels lacked flexibility to ensure that there were sufficient staff to meet peoples' needs.

People were protected from harm and abuse as they were cared for by staff that had undertaken relevant training and knew what to do if they had concerns.

People were supported to take their medicines by staff that had received training. There were safe systems in place for the storage, administration and disposal of medicines.

Is the service effective?

Requires Improvement

The home was not consistently effective.

People were asked their consent before being supported. Appropriate applications to deprive people of their liberty had been made. However, it had not been recognised that one had expired and as a result one person was being deprived of their liberty unlawfully.

People were able to choose what they had to eat and drink, however, they did not have a pleasant dining experience.

Staff had access to training and supervision and were supported within their roles. Peoples' health care needs were met and they had access to relevant healthcare professionals.

Is the service caring?

Good

The home was caring.

People were supported by staff that were kind, caring and compassionate. Positive relationships had developed between

people and staff as well as between each other.

People were involved in decisions that affected their lives and care and support needs and staff respected peoples' right to make decisions.

Peoples' privacy and dignity was maintained and their independence was promoted.

Is the service responsive?

Requires Improvement

The home was not consistently responsive.

Some people had access to external clubs and activities to meet their social needs. However, there was a lack of meaningful activities or stimulation for all people.

Care plans documented peoples' individual social, emotional and health needs but lacked detail and had not been updated to reflect peoples' current needs and to ensure that staff were provided with the most up-to-date information to enable them to meet peoples' needs.

People and their relatives' were made aware of their right to complain and provide feedback about peoples' care.

Is the service well-led?

Inadequate

The home was not well-led.

The home did not have a registered manager. There was a lack of quality assurance processes to ensure the delivery of high quality care and to drive improvement.

Records were not always completed to enable effective monitoring or guidance for staff. The registered person had not notified CQC of situations and incidents that had occurred within the home.

People and staff were positive about the management and culture of the home.

Oak House Residential Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection took place on the 3 January 2017 and was unannounced. The inspection team consisted of one inspector and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The home was last inspected in October 2015, where we found the provider was in breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because we identified concerns with regard to a lack of mental capacity assessments in relation to specific decisions, a lack of deprivation of liberty safeguards (DoLS), a lack of audits to monitor the systems and processes within the home to ensure they were effective and meeting peoples' needs and a lack of notifications submitted to CQC. The home received an overall rating of 'Requires Improvement'. After our inspection in October 2015, the provider wrote to us to say what they would do to meet the legal requirements in relation to these breaches.

On this occasion we did not ask the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the home, what the home does well and improvements they plan to make. Prior to the inspection we looked at the previous inspection report and information that had been shared with us. We used this information to decide which areas to focus on during our inspection.

During our inspection we spoke with three people, two care staff and the manager. After the inspection we contacted two healthcare professionals. Some people had complex ways of communicating and most people had limited verbal communication. We spent time observing care and used the short observational framework for inspection (SOFI), which is a way of observing care to help us understand the experience of

people who could not talk with us. We reviewed a range of records about peoples' care and how the service was managed. These included the care records for four people, medicine administration record (MAR) sheets, three staff training and support and employment records and records relating to the management of the home. We observed care and support in the communal lounges and dining room during the day. We also spent time observing the lunchtime experience people had and the administration of medicines.

Requires Improvement

Is the service safe?

Our findings

At the previous inspection on 19 October 2015, recommendations were made that the provider considered current good practice guidance in relation to risk management and peoples' access to call bells. At this inspection, although people could independently mobilise, there were concerns with regard to peoples' cognitive abilities and their understanding of how to use a call bell should they need to summon staff assistance. The building is spread over three floors and there is one member of staff working during the night. There were no risk assessments in place to identify this risk and no guidance for staff to follow in relation to ensuring that people, when in their rooms, were safe. When this was raised with the manager they explained that staff who worked during the night shift undertook regular checks to ensure peoples' safety. However, there was no evidence to support this.

Risks associated with the safety of the environment and equipment were not always identified and managed appropriately. Regular checks to ensure fire safety had not always been undertaken. For example, checks to ensure that the fire alarms and emergency lighting were correctly working had not been completed for four months. There was a potential risk, that by not ensuring that these were working effectively, by undertaking the regular checks, that faults would not be identified and the equipment may not work in the event of an emergency. Personal emergency evacuation plans which informed staff of how to support people to evacuate the building in the event of a fire had not been completed for all people. The provider had a policy for the care of substances hazardous to health (COSHH), that stated, 'Always ensure that the COSHH cupboard, where the substances are housed, is kept locked at all times'. However, staff had not adhered to this policy. Observations showed that cleaning products were stored in a dis-used shower, in a bathroom that people accessed to use the toilet facilities. Further observations showed that other cleaning products, that were stored in the COSHH cupboard, were not locked away. There was a potential risk that people, particularly those who lacked capacity to understand the risk, could have come into contact with these substances and this could have caused them harm.

There was a lack of recording when an accident or incident had occurred. The provider had an incident policy which stated, 'Record all incidents on the incident form, it must be recorded clearly and accurately. Do this at the first opportunity, whilst the facts are still clear in your mind'. However, staff had not adhered to this policy. Although daily care records had been updated to recognise that there had been an incident or accident, there were no individual accident or incident records and as a result there was a risk that staff would not be made aware of such events taking place as the information could become lost in the main body of daily records. Recording information in this way meant that entries lacked detail with regard to the factors leading up to incidents, the incident itself and the injuries sustained. The provider had failed to take action in response to the incidents and accidents that had occurred. For example, care plans and risk assessments had not been reviewed or amended in response and therefore new risks were not identified or managed appropriately. Records for one person, who sometimes displayed behaviours that challenged others, informed staff that the person could sometimes be verbally abusive but had not attempted to strike anyone. However, daily records showed that there had been an increase in the frequency of incidents where the person had been verbally abusive to others. There had also been several occasions when the person had been physically abusive to staff and other people and one incident had resulted in an injury. Although the

manager and staff were managing the situation as best they could, the persons' care plan and associated risk assessment had not been updated to reflect this change in behaviour and therefore staff were not provided with clear guidance as to how to manage the challenging incidents in a consistent way. When staff were asked how they supported the person to minimise the occurrence of these incidents, one member of staff told us, "There is no real guidance, X is as X is".

At the previous inspection, although treatment plans from external healthcare professionals had been implemented, such as the fortifying of food to increase peoples' calorie intake, people who were at risk of malnutrition were not always regularly weighed to ensure that they were not losing more weight. Records, to ensure that their food and fluid was monitored were not in place and as a result there was no monitoring or oversight of what people were eating on a daily basis. At this inspection records showed that people had been weighed every four months. The National Institute for Health and Care Excellence (NICE) guidance for nutrition states that nutrition support should be considered for people with a low BMI and who have had unintentional weight loss of more than 5% of their body weight over a three-six month period. Records for six people showed that they had lost significant amounts of weight ranging from eight to fifteen pounds within a four month period. It was not evident if this had been recognised and analysed or what action had been taken in response. When this was raised with the manager they told us that they had not identified that people had lost such large amounts of weight within a short period of time. They went on to explain that some people had been overweight and had needed to lose weight, however it was unclear within peoples' care plans if this was an identified need and something which they had consented to or that efforts had been made to support them to lose weight. When asked about other people who had lost significant amounts of weight, the manager was unable to explain the reasons for this or able to explain why this had gone unrecognised and therefore no action taken in response. Due to the lack of records to identify what people had eaten on a daily basis it was not possible to identify the reasons why people had been losing weight, such as if people had been refusing food.

When asked if they felt safe, one person told us, "Definitely". However, we found areas of practice in need of improvement. Staff told us that there was sufficient staffing to meet peoples' needs. Staffing levels consisted of two members of staff and the manager during the day and one member of staff during the night. Although this number had been assessed as sufficient by the provider, there had been recent changes in the needs of one of the people living in the home and as a result the person had often displayed behaviours that challenged others. There had been several incidents when the person had been both verbally and physically abusive to staff. When asked if the staffing levels had been increased to meet the persons' additional needs, staff told us that they had not. Staff told us that due to the persons' increased needs it had sometimes impacted on the time that they had to spend with the other people in the home as they were having to spend their time attempting to diffuse potentially challenging situations. When the issue of only having one member of staff working during the night was raised with the manager, they told us that they felt that this did not pose an issue as the person tended to spend their time in their room during the night. However, there were no lone working risk assessments in place to identify the risk to the member of staff. The provider had not ensured that the staffing levels were flexible to meet peoples' needs and had not increased the staffing levels to ensure that staff were able to safely and effectively meet peoples' needs during a time of potential crisis. The provider was not doing all that was reasonably practicable to mitigate risks. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff had a good understanding of safeguarding adults, they had undertaken relevant training and could identify different types of abuse and knew what to do if they witnessed any incidents. Referrals to the local authority had been made when there were concerns over a person's safety. There were whistleblowing and safeguarding adults at risk policies and procedures. These were accessible to staff and they were aware of how to raise concerns regarding peoples' safety and well-being. A whistleblowing policy provides staff with

guidance as to how to report issues of concern that are occurring within their workplace.

People were cared for by staff that the provider had deemed safe to work with them. Prior to their employment commencing identity and security checks had been completed and their employment history gained, as well as their suitability to work in the health and social care sector. This had been checked with the Disclosure and Barring Service (DBS). The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with vulnerable groups of people.

People were assisted to take their medicines by staff who had been trained and assessed as competent to administer medicines. Safe procedures were followed when medicines were being dispensed and administered and peoples' consent was gained before being supported. Medicine records showed that each person had a medicine administration record (MAR) which contained information on their medicines. Records had been completed correctly and confirmed that medicines were administered appropriately and on time. Medicines were stored correctly and there were safe systems in place for receiving and disposing of medicines. People told us that they were happy with the support they received.

Records in relation to the administration of certain medicines were not always in place. People had been prescribed medicines that they could take as and when they required them. The National Institute for Health and Care Excellence (NICE) quality standards 'Managing Medicines in Care Homes' recommends that care homes should ensure that a process for administering 'when required' medicines is included in the care homes medicines policy. It states that policies should include clear reasons for giving 'when required' medicine, minimum time between doses if the first dose has not worked, what the medicine is expected to do, how much to give if a variable dose is prescribed, offering the medicines when needed and not just during 'medication rounds' and recording 'when required' medicines in peoples' care plans. Although the provider had a medicines policy, there were no guidelines that related to individual people for staff to follow in relation to 'as and when required' medicines. This was raised with staff who explained that they knew people well and were able to ask them if they required any 'as and when required' medicines or would discuss as a staff team and make a decision. However, one person who was prescribed 'as and when required' medicines was unable to indicate to staff when they might require these medicines. Staff told us that they would be able to notice if there were changes in the person's condition and discuss this as a team and a decision would be made as to whether the person required their 'as and when required' medicines. Staff were not provided with clear, recorded guidance to follow in relation to 'as and when required' medicines. This meant that people may not have had access to medicines when they needed them or that they may have been administered in an inconsistent way. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires Improvement

Is the service effective?

Our findings

At the previous inspection on 19 October 2015, the provider was in breach of Regulation 11 and 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because there were concerns with regard to the lack of mental capacity assessments for people who had been identified as not having capacity to make specific decisions and the lack of a Deprivation of Liberty Safeguard (DoLS) application in relation to a person who used bed rails. In addition, the lack of support and supervision for staff was also identified as an area of practice requiring improvement. After the inspection the provider informed us of what they would do to meet the legal requirements in relation to this regulation.

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 they lack mental capacity to make particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to 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 and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

At this inspection we checked whether the provider was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. It was evident that improvements had been made. People were asked their consent for day-to-day decisions and these were respected by staff. Due to peoples' cognitive abilities and the fact that they would be unable to leave the home unaccompanied, DoLS applications had been made for all people. No one used bed rails within the home.

At the previous inspection there were concerns with regard to the management of some peoples' finances. Records showed that some people had their finances managed by the previous registered manager. However, there were no mental capacity assessments in place to identify if people lacked capacity to manage their own finances and no records in place to state that the registered manager had a legal right to manage peoples' finances. At this inspection there was a lack of mental capacity assessments for specific decisions such as people managing their finances. However, improvements had been made in regards to the management of peoples' finances as they had their finances managed by the local authority or their lasting power of attorneys.

There had been improvements with regard to the application of DoLS. However, a DoLS application that had been authorised by the local authority had expired. Information had been shared with us by the local authority, who had conducted an audit at the home, within the audit it had been identified that a discussion had taken place with the manager, during which they had shown an understanding of the provider's responsibility to ensure that DoLs applications were sent to the local authority to be reviewed and renewed 21 days before their expiry. However despite this, the provider had failed to apply to have the DoLS reviewed and authorised. Therefore the provider had not ensured that care and treatment was provided with the consent of the relevant person. This was a continued breach of Regulation 11 of the Health and Social Care

Act 2008 (Regulated Activities) Regulations 2014.

People did not all have a positive dining experience. People had been provided with a degree of choice with regard to what they had to eat and drink. Care staff prepared the meals. There was a menu which was repeated every four weeks, people were provided with a choice of two main meals and could choose other alternatives if they disliked the options available. People had their main meal in the evening and a lighter lunch that consisted of sandwiches, fruit and yoghurt. People could choose where they had their lunch, most people chose to have their meals in the main dining room, whereas others chose to have their meals in their rooms and this was respected by staff. The dining room did not create a pleasant atmosphere for people to eat their meals. The Alzheimer's Society suggests that as dementia progresses eating can become difficult for some people. It states that, 'The environment plays an important part in the eating and drinking experience. A good mealtime experience can have a positive impact on the person's health and well-being'. Within the tips provided to carers, it stated, 'Make the environment as appealing to the senses as possible. Familiar sights such as tablecloths, flowers and playing soothing music at mealtimes can all help'. Observations showed that these were not in place for people and instead people ate their meals in silence with staff standing at the end of the room observing them, creating an institutional atmosphere. This is an area of practice in need of improvement.

At the previous inspection, although the provider had a supervision policy that stated that staff should receive supervision six times per year, staff had not received supervision for over a year. At this inspection it was evident that improvements had been made. Records showed and staff confirmed that they had received regular supervision that had enabled them to discuss their practice and areas of learning and development. Therefore the provider was no longer in breach of this regulation. Staff felt well supported and told us that they could approach the manager and the provider at any time.

A majority of staff had worked at the home for several years. New staff had been supported to learn about the providers' policies and procedures as well as peoples' needs. The manager explained that when new staff were recruited they would be supported to complete a thorough induction and as part of this they would be encouraged to complete the Care Certificate. The Care Certificate is a set of standards that social care and health workers can work in accordance with. It is the minimum standards that can be covered as part of the induction training of new care workers. Staff had completed training which the provider considered essential. There were links with external organisations to provide additional learning and development for staff, such as the local authority and the dementia in-reach team. The dementia in-reach team provides advice, training and information for care homes that provide care to people living with dementia. Some staff had also achieved diplomas in health and social care. Staff told us that the training they had undertaken was useful and enabled them to support people effectively.

People had access to regular healthcare. Records showed that people had been supported to access the GP, opticians, audiologists, chiropodists, physiotherapists and psychiatrists to maintain their health and well-being.

Good

Is the service caring?

Our findings

At the previous inspection on 19 October 2015, we found that people, or their relatives, had not been asked about their preferences with regard to their end of life care and there were no advanced care plans in place. We recommended that the home considered guidance in relation to advanced care planning so that conversations with people, about their preference at the end of their lives, could take place. At this inspection records showed that conversations with people and their relatives, if this was appropriate, had taken place, and peoples' rights had been respected if they did not want to discuss the topic.

The home had a warm, friendly and relaxed atmosphere and people appeared to be content. When asked what the best thing about the home was, one person told us "All the staff - they're very kind, the food and my bedroom". People were cared for by kind and caring staff who had worked at the home for a number of years and who knew their needs well. It was apparent that positive relationships had been developed. There were warm and friendly interactions between people and staff and people told us that they liked the staff and that they were happy living at the home. When asked what they liked about living at the home, one person told us "All the staff, they're very kind".

People were encouraged to maintain relationships with one another as well as with their family and friends. People told us that they were able to have visitors' to the home and that they were welcomed and our observations confirmed this. Observations also showed people engaging in conversations with one another throughout the day. One person told us, "We've always got someone we can go and talk with. Most of us get on well together. We are very lucky here. It's not complicated".

Peoples' differences were respected and staff adapted their approach to meet peoples' needs and preferences. People were able to maintain their identity, they wore clothes of their choice and their rooms were decorated as they wished, with personal belongings and items that were important to them. Diversity was respected with regard to peoples' religion. One member of staff told us, "X is religious, they have religious pictures in their room and we put on 'Songs of Praise' for them." Although there were no formal residents' meetings observations showed that people were asked their preferences and opinions and they were encouraged to be involved in decisions that affected their care. The provider had recognised that people might need additional support to be involved in their care, they had involved peoples' relatives when appropriate or their paid representative. People who are being deprived of their liberty in care homes have a statutory right to have a representative to support them to exercise their rights under the Mental Capacity Act. If there are no appropriate, willing or able friends or family to take on this role, then a paid representative will be appointed. This is someone who can offer support to enable a person to express their views and concerns, access information and advice, explore choices and options and defend and promote their rights.

Peoples' privacy was respected and maintained. Observations showed that when people required assistance from staff that staff did this in a discreet and sensitive way. People confirmed that they felt that staff respected their privacy and dignity as they knocked on their doors before entering their rooms. Some people held keys to their room so that they could lock their door to ensure that their privacy was

maintained. Observations showed staff discreetly and sensitively supporting people to maintain their personal care needs. People were able to be as independent as they wanted to be, however, some people did not always want to participate in tasks to promote their independence. When asked how staff promoted independence, one member of staff told us, "We leave people to care for themselves as far as possible, like making sure water temperature is safe and letting someone carry on. We can advise on clothes but make sure people choose for themselves if they can".

Requires Improvement

Is the service responsive?

Our findings

People were central to the care provided, were involved in decisions that affected their care and supported to choose how they spent their time. One person told us, "I've lived here many years, I like it". However, despite this positive comment, we found areas of practice in need of improvement.

People were supported to make choices. Observations showed staff respecting peoples' wishes with regard to what clothes they wanted to wear, what they had to eat and drink and what they needed support with. Peoples' needs had been assessed when they first moved into the home and care plans had been devised, these were person-centred and documented the persons' preferences, needs and abilities. Person-centred means putting the person at the centre of the planning for their lives. However, reviews had not always taken place and there was a lack of detail in peoples' care plans and associated risk assessments and as a result staff were not always provided with up-to-date information about peoples' care and support needs. For example, records for one person, who had been involved in an incident, had not been reviewed or changed to reflect the change in the person's needs and condition.

Care plans contained information about peoples' interests and hobbies. The Alzheimer's Society states that spending time in meaningful activities can continue to be enjoyable and stimulating for all people, particularly those living with dementia and that taking part in activities based on the interests and abilities of the person can significantly increase their well-being and quality of life. Staff had taken this into consideration for some people. For example, one person enjoyed watching football, this had been taken into consideration and the person had been supported to purchase a season ticket so that they could go and watch football with support from staff. The person told us how much they enjoyed football and that they had visited the local stadium. Some people enjoyed joining in with daily living tasks such as dusting and observations showed one person putting on their apron before starting their tasks once they returned from their day service. One person told us, "I don't like going out very much so I do dusting and I must do hoovering later".

There was however, a lack of stimulation and interaction with people and an over reliance of external services to occupy peoples' time. Some people had access to activities through local clubs, support groups and day services and were able to tell us how much they enjoyed these. One person had been supported by an external club to go on holiday. However, not all people attended external clubs or day services. Observations showed that these people spent their day watching television. Observations showed two people watching the television in the communal lounge. A film had been put on the television and one person appeared to enjoy watching this, however, the other person told us that they did not like it and would have to wait until the film was finished before watching something else. A healthcare professional told us, "It is our belief that the home still needs to develop meaningful person-centred occupation for their residents with dementia. There are minimal dementia specific resources available. The home is used by residents with learning disabilities who attend day centres and a possible consequence is that the home still needs support with understanding their role in delivering this aspect of care to their other residents". When the lack of meaningful activities and stimulation was raised with the manager they explained that people had a right to refuse to take part in activities and choose not to participate, however, there was no evidence

that people had been provided with this choice as there were no meaningful activities or sources of stimulation that people could choose to partake in. The manager told us, "We don't push activities here, even though the local authority and dementia services think we should." The lack of meaningful activities and stimulation for people is an area of practice in need of improvement.

There was a complaints policy in place, this was clearly displayed on a notice board for people to access if they needed to. There had been no complaints about the care provided since the previous inspection. The provider welcomed feedback and there was a suggestions box in the hall for people to use to make their comments known.

Inadequate

Is the service well-led?

Our findings

People liked the manager and staff told us that the home was managed well. One member of staff told us, "She is doing really well, management is better. The owner comes in more often. He wants it to be a good home. He tells us we can call him any time if we have concerns we can't take to the manager". However, despite this positive comment we found areas of practice that required improvement.

The home is the only home owned by the provider. At the previous inspection the current manager had been the deputy manager. At this inspection they had been in post as manager for 12 months and had started the process of applying to be registered manager, however they had not taken reasonable steps to complete this process in a timely manner and the home had been without a registered manager for 12 months. Part of the provider's condition of registration states that a registered manager must be in place, therefore the provider was in breach of their registration. The provider had notified us that the previous registered manager had left employment; however, neither they nor the previous registered manager had submitted an application to deregister with the CQC. This breach of condition is being dealt with outside of the inspection process.

At the previous inspection on 19 October 2015, the provider was in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and Regulation 18 of the Care Quality Commission (Registration) Regulations 2009. This was because there were concerns regarding the lack of quality assurance processes to ensure that the systems and processes used within the home were effective, the inappropriate storage of records to ensure that confidentiality was maintained and the lack of notifications to inform CQC of events that had occurred within the home. Further areas in need of improvement related to the updating of organisational policies and the appropriate management of peoples' finances. We asked the provider to submit an action plan, within a specified timescale to inform us of what they would do to meet the legal requirements in relation to the regulations. However, the provider did not send us the action plan within the agreed timescale and this was not received until five months after the inspection. The regulations state that the provider must send to the Commission, when requested to do so and by no later than 28 days from the request, a written report setting out how their plans for improving the standard of the service provided to people with a view to ensuring their health and welfare. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The manager was still developing in their role and was yet to fully understand their role and responsibilities and this was evident within their answers to questions and their understanding of the requirements of the regulations. The provider had failed to oversee the running of the home during this time of transition and development and as a result the provider had not ensured that they operated effective systems and processes to make sure they assessed and monitored their service against the regulations. The provider has a responsibility to ensure that this happens at all times to ensure that they are responding to the changing needs of people and that the service is continuously improved.

At the previous inspection it had been recognised that there was a lack of quality assurance processes and those that had taken place had not been clearly documented. The regulations state that providers must

have systems and processes such as regular audits of the service to enable them to assess, monitor and improve the quality and safety of the service. However, despite this being an area of practice that was recognised as requiring improvement at the previous inspection we found that at this inspection no improvements had been made. At this inspection the only audit that took place related to the medication records and the manager explained that this was a visual check and that this was not recorded. There were no other quality assurance systems and processes used within the home to enable the provider to have oversight and awareness to ensure that the systems and processes used were effective. At the previous inspection quality assurance questionnaires had been sent to people and their relatives to gain their feedback, however, at this inspection there were no mechanisms in place to gain peoples' feedback with regard to the service they received.

The lack of quality monitoring meant that shortfalls in some of the systems in place had not been recognised. For example, the lack of audits meant that the provider had not recognised that cleaning products were not being stored correctly, that accidents and incidents were not being recorded or analysed and that some health and safety checks had not been completed. It had also failed to identify that a number of people had lost significant amounts of weight, that DoLS applications had not been submitted to ensure that people were not being deprived of their liberty unlawfully or that quality assurance questionnaires had not been sent to people or their relatives to gain their feedback.

There was a lack of effective governance, including assurance and auditing systems and processes, to assess, monitor and drive improvement in the quality and health and safety of the services provided, as well as the experience of people using the service. This was a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the previous inspection the provider had not notified us of a safeguarding alert that had been raised by an external professional. Part of a providers responsibilities under their registration with the Care Quality Commission is to have regard, read and consider guidance that is provided in relation to the regulated activities that they provide, as it will assist them to understand what they need to do to meet the regulations. One of these regulations relates to the providers responsibility to notify us of certain events or information. At this inspection, records showed that there had been another safeguarding alert raised, this time by the manager of the home. In addition to this there were several DoLS authorisations in place and a death that had occurred. The provider had failed to inform us of these events. Providers are required to inform CQC of these incidents to enable us to have oversight to help ensure that appropriate actions are being taken and to ensure peoples' safety. When this was raised with the manager they explained that they were unaware that they needed to notify CQC of such events and were unaware of the guidance. However, within the action plan that the manager had completed after the previous inspection they had recognised that notifications had not been made under the previous management and had agreed that this was an area of practice that needed to improve. This was a continued breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

At the previous inspection it was recognised that organisational policies had not been updated for several years and did not reflect changes in legislation to ensure that staff were provided with guidance that reflected current legislation and best practice guidance. At this inspection improvements had been made. The manager was in the process of devising new organisational policies, to ensure that staff were provided with appropriate guidance within their roles, and had plans to improve and extend these even further, however these were yet to be sustained and embedded in practice.

At the previous inspection there were concerns with regard to the storage of records in relation to staff files, peoples' care plans and electronic information held on a computer. At this inspection improvements had

been made. The provider had purchased lockable cabinets to ensure that records such as staff files and peoples' care plans were stored securely and laptop computers were shut down after use to maintain confidentiality.

There were links with external organisations to support staff to provide the most effective and appropriate care for people and that staff were able to learn from other sources of expertise. These included links with the local authority and the dementia in-reach team. The manager also worked closely with external health care professionals to ensure that peoples' needs were met. A healthcare professional told us, "The home manager welcomes us into the home and asks for appropriate support and advice. She is a regular attender at the practice development forum for managers. The home is also represented, on occasions, at the activities workers forum".

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 will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents Regulation 18 Care Quality Commission (Registration) Regulations 2009 Notification of other incidents. Regulation 18 (2) (e) of the Care Quality Commission (Registration) Regulations 2009. Notification of other incidents. The registered persons had not notified the commission of any abuse or allegation of abuse in relation to a service user.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2014. Need for consent. Regulation 11(1) (3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Need for consent. The registered person had not ensured that suitable arrangements were in place for obtaining and acting in accordance with the consent of service users or establishing and acting in accordance with the best interests of the service user in line with Section 4 of the Mental Capacity Act 2005.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2014. Regulation 12 (1) (2) (a) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safe care and treatment. The registered person had not assessed the risks to the health and safety of service users receiving care or treatment. Neither had they done all that was reasonably practicable to mitigate any such risks.

The enforcement action we took:

When the Care Quality Commission visited Oak House Residential Home unannounced on 3 January 2017, we found the service was failing to meet the fundamental standards that people should be able to expect. As a result, CQC has issued a formal warning to Oak House Residential Home, telling them that they must improve

Regulation 12: Safe care and treatment.

The provider had not prevented people from receiving unsafe care and treatment nor prevented avoidable harm or risk of harm

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2014. Good governance Regulation 17 (1) (2) (a) (b) (c) (e) (f) (3) (a) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Good governance.

The enforcement action we took:

When the Care Quality Commission visited Oak House Residential Home unannounced on 3 January 2017, we found the service was failing to meet the fundamental standards that people should be able to expect. As a result, CQC has issued a formal warning to Oak House Residential Home, telling them that they must improve

Regulation 17: Good Governance.
The provider was failing to ensure that systems and processes were in place to enable them to assess, monitor and improve the service provided.