Laudcare Limited

Oaktree Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 17 and 18 February 2016. We carried out this inspection because we found a number of breaches of regulation during the last inspection in September 2015. The provider sent us an action plan telling us they would be compliant by December 2015.

Oaktree Care Home is registered to provide personal and nursing care for up to 78 people. The service is divided over two separate floors. The ground floor called Bluebell is for those who require nursing care and the upper floor is dedicated to those people living with dementia and is called Primrose.

There was a manager in post. The manager commenced in post in October 2015. They had not submitted an application to become the registered with the Care Quality Commission (CQC). A registered manager is a person who has registered with the CQC to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.'

After the last inspection we took enforcement action against the provider. This was to prevent them considering any new admissions on Primrose without prior written authorisation from the Commission. There had been no admissions to Primrose since the last inspection. The regional manager, the manager and the unit manager said they felt that they were now satisfied people were receiving safe and appropriate care and would like to start to admit people to Primrose using a phased approach. The provider must contact the Commission prior to any new admissions.

There had been significant improvements since our last inspection in respect of how people were being treated, how staff were responding to their care needs ensuring they had access to appropriate professionals. There was a clear and committed management team working across all areas of the home. Staff confirmed since the last inspection there had been improvements on Primrose and they felt there were a more cohesive team which was being led by the unit manager.

There were some areas that required further improvement including the management of complaints and ensuring people received their medicines safely. This was because there was a lack of guidance for staff about 'when required' medicines such as pain relief and medicines to reduce anxiety. Improvements were required in respect of stock control where medicines were not given from pre-packaged 'blister' packs. This would mean there would be a system to pick up quickly if medicines had not been administered at the correct time.

People were supported by sufficient staff. However, it was recognised by the provider, the manager, staff, relatives and people who use the service that there was a high usage of agency staff. This was having an impact on the delivery of care because the agency staff were not always responsive to people's changing needs. Health care professionals had seen some improvement but remained concerned that the agency staff did not always know the person well enough. Steps were being taken by the provider to recruit to the

vacant staff posts.

People were safe because where their care needs had changed or an incident had occurred, appropriate action had been taken. Where incidents were identified as potential abuse; staff were reporting and an investigation was completed. This included reporting incidents and accidents to the local safeguarding team and submitting notifications to the CQC. Notifications tell us about significant events that happen in the service. We use this information to monitor the service and to check how events have been handled.

People were receiving care that was responsive and effective. This had significantly improved since our last inspection. Care plans were in place that described how the person would like to be supported. The care plans provided staff with information to support the person effectively. Other health and social professionals were involved in the care of the people living at Oaktree.

People were protected from the risk of abuse because there were clear procedures in place to recognise and respond to abuse and staff had been trained in how to follow the procedures. Systems were in place to ensure people were safe including risk management, checks on the environment and safe recruitment processes.

Staff were caring and supportive and demonstrated a good understanding of their roles in supporting people. Staff on Primrose had received training and support that was relevant to their roles. Systems were in place to ensure open communication including team meetings and daily handovers. A handover is where important information is shared between the staff during shift changeovers. This ensured important information was shared between staff enabling them to provide care that was effective and consistent. Staff on Bluebell told us they felt that all the resources and support had been given to the staff on Primrose and as a consequence standards had slipped on Bluebell. The management team were aware and were working with the unit manager and staff team on Bluebell to address their concerns.

People were involved in structured activities in the home. These were organised taking into consideration the interests of the people and were organised in small groups or an individual basis.

People's views were sought through care reviews. Systems were not in place to ensure that complaints were responded to, and learning from these was taken to improve the service provided. This was because not all complaints we had been made aware of had been recorded.

The provider had introduced systems to assess, monitor and improve the quality of care. This meant the provider and the manager had a better understanding of what was happening in the service and could respond to concerns or risks promptly. Where there were shortfalls the manager had worked with the unit managers, staff and people to develop an action plan to address these.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe. This was because the people were often supported by agency staff that did not always know them well.

Some improvements were still required to ensure people received their medicines safely. This was because there was a lack of information about as and when required medication to guide staff and improvements were required to check the amount of medicines held in the home.

Risks to people were being assessed and monitored. Where risks had been identified, management plans were now in place. Staff were provided with sufficient and up to date information which assisted in keeping people safe.
People receiving a service were kept safe from harm because staff were aware of the actions to take to report their concerns.

Is the service effective?

Good

The service was effective.

People's freedom and rights were respected by staff who acted within the requirements of the law.

Staff had a good understanding of people's care and support needs. People were supported by staff that had the necessary skills and knowledge.

People had access to other health care professionals when required.

People's nutritional needs were met and this was kept under review to ensure people were having enough to eat and drink.

Is the service caring?

Good

The service was caring.

People were treated with compassion, kindness, dignity and respect. They were asked regularly about their individual preferences and checks were carried out to make sure they were

receiving the care and support they needed.

Staff were knowledgeable about the individual needs of people and responded appropriately. Staff were polite and friendly in their approach.

Is the service responsive?

Requires Improvement

The service was responsive to people's changing and on-going support needs.

People felt confident to raise concerns. However these were not always recorded so that any learning could take place.

People's individual needs were planned for, evaluated and delivered consistently. Improvements had taken place since the last inspection this continues to be embedded into practice ensuring care was tailored to the person.

Is the service well-led?

Requires Improvement

There had been significant improvements since the last inspection there is now a clearer leadership structure and staff felt better supported in their roles. The manager had yet to be registered with the Care Quality Commission.

The culture of the home was changing and the improvements have benefited people being treated in a more person centred way. This needs to continue and be embedded in to the day to day practice of staff.

Systems were in place to monitor and check on the quality of the service. Where there were shortfalls action plans had been developed.

Oaktree Care Home

Detailed findings

Background to this inspection

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

This inspection took place on the 17 and 18 February 2016 and was unannounced. The inspection team consisted of two inspectors, two pharmacy inspectors 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. We spent time on both floors. The upstairs was home to people living with dementia and called Primrose. The downstairs was called Bluebell and was for people with nursing needs.

Prior to the inspection we looked at information about the service including notifications and any other information received by other agencies. Notifications are information about specific important events the service is legally required to report to us.

We contacted health and social care professionals to obtain their views on the service and how it was being managed. This included South Gloucestershire Council's commissioning team, safeguarding team and the local Commissioning for Continuing Health. You can see what they told us in the main body of the report.

We conducted a Short Observational Framework for Inspection (SOFI 2). SOFI 2 provides a framework for directly observing and reporting on the quality of care experienced by people who cannot describe this for themselves. This observation was carried out on Primrose.

We looked at ten people's care records to see if they were accurate and up to date. We also looked at records relating to the management of the service. These included staff rotas, recruitment, training records and audits that had been completed.

We spoke with the manager, deputy manager, and two senior representatives from Laudcare Ltd, and two registered nurses, eight care staff, 14 people who used the service and eight relatives and visitors.

Requires Improvement

Is the service safe?

Our findings

There had been some improvements since our last inspection. We have confidence that people were supported safely by the staff employed by the provider. However, this was not always the case when agency staff were working in the home. This was because there were several incidents where agency nurses had not followed the policies and procedures to ensure people were safe. This included ensuring people had their medicines in a timely manner or medical attention was sought promptly. A relative told us they had to go and collect some prescribed medicines over the weekend as there was insufficient staff. When we checked the rota there were sufficient numbers of staff. However, there was an agency nurse managing the shift along with three regular and two agency care staff. The agency staff had not followed procedure to ensure the person had their prescribed medicines available which caused upset to the family and the person.

We found improvements had been made in the handling of medicines since our last inspection, however further improvements were needed to make sure that people's medicines were always managed safely.

We looked at the current medicines administration records on each floor of the home. The pharmacy supplied most medicines using a monthly blister pack system. We looked at a sample of these packs on each floor and found they confirmed the administration records completed by staff. We also checked four medicines on Primrose supplied in standard boxes. We found the records were not completely accurately for three of these medicines. So, staff could not assure themselves that people had always received these medicines correctly. The unit manager told us she would introduce daily checks of medicines supplied in standard boxes, to make sure people received their medicines correctly. A system had been put in place by day two of the inspection.

Some people were prescribed medicines to be given 'when required'. During the medicine rounds, we heard staff asking people if they needed these medicines. We saw protocol's in place for many of these medicines which give staff additional information to help them give medicines in a safe and consistent way. Staff were able to describe when they would give people these medicines. Staff told us they were still working on completing the remainder of these protocols to make sure they were always available to support staff to give people their medicines safely. The lack of information to guide staff meant that people may not receive these medicines consistently and safely.

Systems were in place for staff to record medicines errors. These were checked and investigated to make sure suitable action was taken to reduce the risk of further errors. We saw an example of a recent reported error, where staff had not given a person their pain relieving medicine on the correct day. This increased their risk of pain until the next dose was given. The manager told us the action they were taking to investigate and address this. We saw that staff had taken action to highlight the times this medicine should be given, to reduce the risk of staff missing it. However, we saw that the same mistake had occurred again the day before our inspection. Staff realised this during the inspection.

This was a breach of Regulation 12 (1) and (2) (b) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Safe Care and Treatment.

We saw staff giving some people their morning medicines on Primrose and lunchtime medicines on Bluebell in a safe and respectful way. People received their medicines at a suitable time.

The pharmacy provided printed administration records for staff to complete when they gave people their medicines. We saw some information with people's medicines administration records in their care plans describing how they liked to be supported to take their medicines. Staff completed these records to show when people had taken their medicines and recorded the reason if they were not taken.

Some creams and ointments were kept in people's rooms and applied by care staff. We found that staff recorded the application of these medicines. Staff told us that senior staff checked the records to make sure these medicines had been applied as prescribed. We looked at the creams and ointments kept in three people's rooms. Containers were labelled for the correct person. Staff had dated the container on opening and recorded when they had applied the preparation.

Staff told us they had a number of systems in place for checking that medicines were looked after safely. This included a daily check of medicines for the 'person of the day'. The manager showed us how she could look at information from the audits over a period of time to check that staff looked after and gave people's medicines safely. Medicines were stored safely and securely.

People living on Bluebell (the nursing floor) told us they were concerned about the high use of agency staff. One person told us, "I dread Friday as it is always worse on the weekend when there are staff I do not know; the regular staff are good though". We also spoke with a small group of people who told us that there was a lot of agency staff working in the home throughout the day and night. They said, "Nights are not so good". Relatives we spoke with were also concerned about the high use of agency staff that did not know people as well as the regular staff.

Sufficient staff were supporting people. Staff confirmed there were always enough staff to support people safely but acknowledged there was a high use of agency. The manager told us since the last inspection this had been reduced but on average 175 care staff hours and 150 nurse hours were still being covered by agency staff on a weekly basis. The manager told us they tried to ensure there was always regular staff including a nurse working alongside the agency staff.

The rotas showed there were sufficient numbers of staff. Two new nurses had been employed since our last inspection and ongoing recruitment continues for both care and nursing staff. Whilst there was a high use of agency staff it was evident steps were being taken to reduce this.

At the last inspection we were told the service would be block purchasing regular agency staff. This was to enable the agency staff to get to know the people and the routines of the service. The manager told us the provider had recently introduced a new system which meant multiple agencies were contacted to cover the available shifts. This meant sometimes it was not familiar agency staff working in the home. Visiting professionals also told us that when they visited there were often agency nurses that did not know people very well and could not provide them with the appropriate information. The manager told us that all agency staff completed an induction to the service and a comprehensive handover.

The manager told us there was an ongoing recruitment drive to cover the vacant posts. This included attending local job fairs to reach a far wider population. The deputy manager confirmed they were taking an active role in the recruitment of new staff.

The provider followed safe recruitment practices. We looked at the recruitment files for four members of

staff and found appropriate pre-employment checks had been completed. All members of staff had at least two satisfactory references and had received a Disclosure and Barring (DBS) check. The DBS helps employers make safer recruitment decisions and prevents unsuitable people from working with people who use care and support services. Checks had been completed on the nurses to ensure they were registered with the Nursing and Midwifery Council (NMC). This meant the provider could be assured the nurses were fit to practice. The provider had demonstrated compliance to a previous breach from the inspection completed in June 2014.

The provider had demonstrated compliance to a breach in regulation and people now received a safe service because risks to their health and safety were well managed. This included risks due to choking, poor nutrition, pressure wounds, risk of falls and the delivery of personal care. Where risks were identified, care plans were put in place which provided information to staff on how to keep people safe. These had been kept under review and updated as peoples' needs had changed.

Where people required assistance with moving and handling, the equipment to be used was clearly described along with how many staff should support the person to ensure their safely. Staff confirmed they received training in safe moving and handling procedures. We observed people being assisted safely and appropriately in relation to support with transfers using a hoist.

Staff said they felt people were safe. A member of staff told us, "People are better cared for now and as a result are safer". One person told us, "I am safe here, I have my buzzer if I need them I know they are there":

Where people were at risk of developing a pressure wound and required support with changing position, records were maintained of the support provided. Staff were aware of the risk assessments to keep people safe in this area. This had improved since our last inspection and compliance with a breach of regulation had been met.

We observed that there were table cloth clips in place to ensure the table cloths could not be pulled from the table. This was important because there had been an incident where these were not in place and a person had pulled the table cloth and scalded themselves. Staff were aware of the need to ensure these were in place to keep people safe especially on Primrose the floor for people living with dementia. This showed that learning from incidents was taking place to keep people safe.

During the last inspection we found accidents and incidents were not always recorded. Systems had been put in place to enable staff to promptly record any accidents and incidents. The manager had developed a system to track any accidents to ensure appropriate action had been taken and where required an investigation had been completed. From looking at care records we could see that accidents and incidents had been reported and followed up appropriately. For example a person we noted had bruising to their face. This had been clearly recorded, including an accident form being completed, a body map, daily records, an initial investigation and a referral to safeguarding.

Staff told us they had completed training in safeguarding adults and were aware of what constituted abuse and the importance of sharing information where they had concerns. Staff confirmed they would report concerns to the manager or the nurse in charge and these would be responded to promptly. They told us there were policies on responding to an allegation of abuse and whistle blowing. Staff were aware of the role of the Care Quality Commission where they felt their concerns had not been acted upon. The manager had introduced a safeguarding tracker to enable them to monitor any alerts including any action taken and to ensure information was shared with the local safeguarding team and the Care Quality Commission.

There had been 17 safeguarding referrals since the last inspection. These had either been raised directly by the manager and healthcare professionals or from relatives raising concerns. The local authority was still completing their investigations into some of these alerts. There was on-going safeguarding monitoring in place by the local authority because of the high number of concerns that have been raised since the beginning of 2014. The local authority has placed a stop on any new admissions to the dementia suite until improvements could be sustained. The provider had agreed to this arrangement at the last inspection not admit any new people to the floor for people living with dementia.

We took enforcement action against the provider after the last inspection. This was to prevent them considering any new admissions on the dementia floor without prior written authorisation from the Commission. There had been no admissions to the dementia floor since the last inspection. The regional manager, the manager and the unit manager said they felt that they were now satisfied people were receiving safe and appropriate care and would like to start to admit people to the dementia floor using a phased approach. The provider must contact the Commission prior to any new admissions.

The home was clean and free from odour. Staff had received infection control training. Policies and procedures were in place to guide staff on safe practice. Domestic staff were employed to assist with the cleaning of the home. People and relatives confirmed the home was cleaned to a good standard and there were no lingering odours.

Good

Is the service effective?

Our findings

During the last inspection there were numerous concerns raised by relatives, visiting professionals and our own observations showed people were not being supported effectively with their health care and their rights were not being protected. This was on the dementia floor. The provider submitted an action plan on how they were going to address these shortfalls which included providing training to staff and developing systems to monitor the effectiveness of the service provided.

Improvements were observed throughout this inspection with compliance demonstrated to the previous breaches of regulation.

Feedback from health and social care professionals acknowledged that improvements had been noted in respect of how people were being supported. This included staff employed by the home being more knowledgeable about people and being more proactive in reporting concerns about people's health and general well-being. Whilst the feedback was positive, there were concerns raised about the high use of agency staff especially nurses who may not know people as well as the regular staff. A visiting health care professional told us they visited every week and often there was an agency nurse working. They reported they often did not know people and could not find the information required such as weight monitoring records, which would enable them to make a quick diagnosis.

Since the last inspection, the unit manager on Primrose had developed a board that detailed the care and support required in critical areas such as eating textured diets, risks relating to falls and the name of the responsible GP for each person. This meant that staff had a quick overview on how people should be supported safely and effectively. This was useful for staff that were not familiar with people and could be used as a quick reference guide along with the person's care plan and the summary of care that was kept in each person's bedroom.

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 take 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 are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. Improvements have been made since our last inspection. The provider had implemented their action plan to achieve compliance with previous breaches in regulation.

Staff were aware where people may lack capacity and told us it was still important to involve them in day to day decisions where they were able. We observed staff seeking consent before any intervention and waiting for a response before proceeding. This was confirmed by people who told us, staff said such things as: 'would you like me to…,' 'would you mind if I…' and 'will it be alright if I...' We observed people being asked if they were happy for staff to assist before helping them.

We saw that some people had refused care. Staff told us this was respected, however they also stated they had a duty of care to go back and offer later in the day. Where people had refused care this was recorded and monitored. Staff were aware of the importance of involving relatives and other professionals where a person was continually refusing care and putting themselves at risk of neglect, especially where the person lacked mental capacity. A relative had voiced concerns that they felt the staff did not always do enough when food was refused on a regular basis. Records showed the staff had consulted with the person's GP and a care plan was in place to guide staff on how they should encourage the person to eat. The care plan included food preferences. In addition regular weight monitoring was being completed. This showed the staff were trying to support the person taking into consideration their preferences and personal needs.

The unit managers told us best interest meetings were held where people lacked mental capacity and this included seeking the views of the person's relatives and professionals involved in their care such as the GP. Records were maintained of best interest meetings detailing the decision making process and who was involved. The unit managers were linking up so that good practice could be shared across both areas of the home in respect of best interest recording. Staff had received training in the MCA and the DoLS. Further training was being sought from the local authority to develop MCA champions.

Staff knew who had an authorisation in respect of DoLS. The outcome of the application was clearly recorded in people's care plans in respect of any restrictions. This enabled the staff to monitor whether this was effective. The manager had developed a tracker detailing who had an authorisation in respect of DoLS, who had been informed for example the Care Quality Commission and when it was due for renewal. The manager told us the process of renewal would be started one month prior to the expiry date. Where an authorisation was in place for a person the Care Quality Commission had been informed. The provider had demonstrated compliance to a breach of regulation.

People's nutritional needs were now being met. Where people had been assessed as being at risk of malnutrition, clear plans of care had been developed. For those people that had been identified as being at risk, increased monitoring was in place including food and fluid charts and weekly weights being completed. Systems were in place to enable the manager to audit and check that staff were following the correct procedures in respect of monitoring people's weights where there was weight loss. Referrals were being made via the GP to speech and language therapists (SALT) for swallowing assessments where people were at risk of choking. Staff were familiar with how people should be supported in respect of the consistency of their diet and when thickening agents were used in drinks. The provider had demonstrated compliance to the breaches of regulation found in September 2015.

We observed people at lunchtime on Primrose. Staff took care to welcome people to the dining room and assist them to a table of their choosing. Menus were on display at each table. People were asked if they wished to change their menu choice, made the previous day and, if so were provided with their choice of food. One person changed their choice from gammon to quiche and said they wanted to eat their lunch in their bedroom. Staff supported the person to take their meal to their bedroom. Drinks were offered with meals. Some people required assistance to eat their meal. Where this was the case staff sat with people and assisted them at their own pace, providing encouragement and maintaining eye contact. People who chose to eat in their room, or were unable to get to the dining area, were supported to eat in their rooms. The

overall mealtime experience was relaxed and enjoyable for people. One staff member said, "Mealtimes are much better organised now and as a result, are more enjoyable for people".

Generally people were happy with the food, commenting: "Food is alright, I have a good appetite and I eat everything they give me"; "Food is quite good I get a choice and plenty to eat"; "Food is ok, a bit repetitive" and, "Meals are not what I would choose to eat at home, but it is well cooked". Care plans included people's likes and dislikes with food. Some people had been assessed as requiring softer food because they were at risk of choking. People received food appropriate to their needs and care was taken to ensure it was well presented.

People had access to a GP. There was a choice of five GP practices that supported the home and some people were able to retain their GP if they lived locally. New systems had been put in place to monitor and record the outcome of health care appointments. Records were maintained of health care appointments, including any treatment and follow ups. For example where blood or urine analysis had been completed then this was followed up with the GP practice to determine if any treatment was required.

Staff told us that a doctor from four of the practices visited weekly to see any of their patients who needed this. This meant that people's health care and treatment could be reviewed regularly. Staff told us they also had support from a pharmacist who had visited to review people's medicines on Primrose and liaise with their doctors. This helped to ensure people received safe and appropriate medicines and treatment.

Other health care professionals were involved such as physiotherapists, speech and language therapists, the community mental health team and care home liaison team. This is a team of professionals that advices the provider and supports people enabling them to remain in the care home. People also had access to a podiatrist and opticians where required. Care records lacked evidence that people had access to a dentist and the manager agreed after the inspection to review this for people living in the home. The manager told us referrals were made as and when required.

Where people were at risk of developing pressure sores a care plan was in place describing how the person should be supported. This included any specialist equipment such as pressure cushions or an air mattress that should be in place to minimise any risks. There were body maps, photographs of healing and information about how staff should support the person with positional changes. The unit manager on Bluebell told us that they regularly liaise with the district nurses and the tissue viability nurses to discuss the best approach to treatment including dressings for people. Nurses confirmed they had attended a training update session on wound care management.

Staff we spoke with were knowledgeable about the people they supported. They were able to tell us about people's needs, their likes, dislikes and preferences. They gave a good account of how they supported them. The information staff gave matched what was documented within people's care plans. Staff confirmed they were involved in the care planning process and would sit alongside the nurses to discuss any changing needs. A member of staff told us the care plan was always evolving as they were getting to know people and more information was received from relatives or the person themselves.

Staff completed core training as part of their induction including safeguarding adults, health and safety, basic first aid, infection control, fire safety, food safety, moving and handling. This was then periodically updated once they had completed their induction. Staff on the Primrose confirmed that since the last inspection they had received training on supporting people in a person centred way, equalities and diversity, dementia care, safeguarding adults and record keeping. However, staff from Bluebell felt they had not received the same level of training as all the resources had gone into the staff working on Primrose. The

manager and the unit managers were aware and had recently discussed this during a staff meeting and were looking at how this could be addressed.

Agency staff completed an induction to the service with records maintained. This included how to access key policies and procedures including reporting and information about people and the general running of the home.

Nurses confirmed they received regular updates on clinical matters such as wound care, the taking of bloods and medicine management. The unit managers were working much more closely than seen at the last inspection with skills, knowledge and expertise being shared. For example there was no nurse who had been trained to take bloods on Primrose so the nurses were supporting from Bluebell. Another example was where Bluebell staff were using the knowledge and skills of a registered mental health nurse working on Primrose to assist with mental capacity assessments. A member of staff told us, "It is no longer us and them, the daily heads of department meeting has helped with this as well".

Staff confirmed they received supervision from a senior member of staff. However the frequency varied depending on the staff we spoke with. Supervisions are a process where staff meet on a on to one basis with a line manager to discuss their performance and training needs. Some staff told us they had monthly supervision and others not so often. Staff on Bluebell told us these had recently not been so frequent. The unit manager of this area was aware and a plan had been put in place.

Oaktree Care Home is purpose built property to provide accommodation, nursing and personal care to 78 older people. The accommodation is arranged over two floors; Bluebell is on the ground floor and supports people with nursing care needs and Primrose supports people living with dementia on the first floor. These areas had only recently been renamed and the manager told us new signage was being ordered so it was clear to people and visitors. There is a lift to enable people to access the first floor.

There was outside space which people on the ground floor could access independently. The manager and the unit managers told us work was being planned for this area to turn it into a sensory garden. There was a key code on Primrose which restricted people's access to the garden area independently and they were reliant on staff or their visitors to support them in this area. The unit manager on Primrose told us they were looking forward to the warmer weather when people would be supported to access this area.

All bedrooms were ensuite and single occupancy. People were supported to personalise their bedrooms. People on Primrose had been supported to put photographs or an aid to their memory on their bedroom door to assist with orientation.

Since our last inspection there had been some improvements on Primrose, the dementia floor, with some redecoration, new furniture being purchased for the lounges and memory boxes being installed outside bedroom doors. Relatives had been encouraged to place personal items in the memory boxes to aid the person to find their bedroom. For example photographs, jewellery or one person had a train as this was what they were personally interested in. Staff acknowledged that this was still work in progress and continued to work with relatives and the person.

There were still some outstanding actions such as making the ends of corridors more interesting for people living with dementia by providing seating or a themed area such as a garden corner. The manager and the regional manager confirmed this was outstanding. A member of staff told us they were interested in in being involved in this piece of work. They told us they were trying to gather different items for people to handle to enhance people's sensory skills, such as handbags containing items for people to touch and feel such as

scarfs, hats and other small items.

We noted that the patio doors leading to the garden from both lounges on Bluebell were in a poor state of repair. This posed not only a security risk but could mean people were sat in draughts. The manager told us these were being replaced with new doors. The regional operations manager confirmed quotes had been obtained and the finance agreed.

There were some additional works being completed on Bluebell which was to provide staff with a larger office and clinic for storing medicines. Staff spoke positively about this. The plan was for a bathroom to be turned into the clinic. This had already been fitted with air conditioning. The present clinic would then be turned into a wet room.

Good

Is the service caring?

Our findings

During the last inspection there were numerous concerns raised by relatives, visiting professionals and our own observations that people were not being treated consistently in a caring manner that showed dignity and respect for the person. This was on Primrose the dementia floor. The provider submitted an action plan about how they were going to address these shortfalls which included, providing training to staff with increased monitoring on how staff supported people.

Improvements were observed throughout this inspection with staff showing many acts of kindness towards people and ensuring their needs were being met promptly. Staff were observed engaged with people not only when completing personal care but sitting with people and chatting about various subjects and engaging in activities.

People appeared to be well cared for; they looked well kempt, hair was groomed and fingernails were clean. They wore clothing that reflected their age, gender and previous life style, footwear was appropriate. People were offered a change of clothing if these had been spoilt during the course of the day.

Staff told us some people preferred to get up later or functioned better later in the morning. Staff told us they respected the decisions of people but continued to offer assistance until they were ready to get dressed or required support with personal care. One member of staff told us, "(Person's name) prefers to stay in their night wear but we will continue to offer support until she is ready". They told us the person had been assisted with personal care and to change their night wear when they first got up. Another member of staff was quite concerned because they could not support a person as the person had been agitated when they were brushing their hair and completing nail care. The member of staff told us they would try again later after the person had their cup of tea. From these conversations it was evident that people were being treated with dignity and respect and the appearance of people was seen as being important to staff.

Care records were person centred and contained information on people's likes, dislikes, hobbies and interests and their life history. Staff said this helped them to get to know people and provided useful information to initiate conversation.

Staff were aware of people's preferences. This included the name they wanted to be known by and the gender of staff they liked to be supported by. One person preferred to be supported by male care staff with their showering arrangements. Records showed that this was now being provided. Where there was not a male carer on that particular floor then a male care staff from the other floor would assist. This showed the staff were accommodating people's wishes.

The Primrose unit manager told us that during daily handovers, staff were reminded about the delivery of personal care including nail care. It was evident that the training and the information being shared had directly impacted on how people were seen by staff. Staff were observed supporting people as individuals and they had a better understanding of how dementia may affect the person. This was observed in how staff treated people throughout the inspection.

People told us, "Staff look after me well they do everything for me, they are all nice", "Staff are kind, they definitely look after me well", "Staff do not sit and talk to me, they are all so busy, but give me time while they are seeing to me", "Staff are very patient and never rough" and, "This is a good home with lovely staff; everybody is very nice, it is the best home in the area". Relatives told us, "I am happy with the care; I can come and visit and walk away knowing my loved one will be cared for and is happy", "I know most of the staff, they are fine and I trust them" and, "Staff were so wonderful to my loved one and so caring in the way they spoke; I was moved to tears".

The atmosphere on Primrose was more relaxed than last time we inspected with people being engaged in activities with staff. A small group session was being held and the member of staff ensured throughout the activity each person was engaged and comfortable. During this session a person shouted out, the member of staff promptly supported the person to be seated more comfortably and offered them a drink. The caring actions of the member of staff evidently had a calming effect on the person.

We observed staff knocking on people's doors and waiting for a response prior to entering their rooms. People were consulted on whether they would like their bedroom door open or shut and whether they would like the light on or off when they went to sleep. This was recorded in the person's care plan under preferences for sleeping. This showed that people were consulted about how they would like to be supported.

A person told us they were doing a piece of work in relation to be treated in a dignified and respectful manner with one of the activity co-ordinators. They showed us a tree that had been painted on the wall in Primrose where people could leave comments on how dignity and respect should be promoted. The person told us, "It's not just about knocking; it is about waiting for us to respond". When asked if this happens they told us, "Most times, but not every member of staff will say 'good morning' and that is just as important". Other people had written down 'to give me choice', 'call me by my name', and 'say good morning to me'. We observed that staff were responding to these suggestions.

People were supported appropriately and sensitively during meal times. Both breakfast and lunch were observed in both areas of the home. People were supported at their own pace with staff clearly explaining what the person was eating when they required assistance. Staff asked if people had enjoyed the meal and whether they had sufficient to eat. When people were supported to leave the dining area, staff clearly explained what was happening and asked for consent before they assisted the person. When people became more vocal or appeared agitated staff quietly supported the person to ascertain what assistance the person required. The actions staff took at the time appeared to calm the person.

Staff were seen to interact with people in a kind and compassionate manner and were heard to refer to people by their preferred name, using appropriate volume and tone of voice. We observed a staff member wiping a person's face with great tenderness, another bending down to eye level and speaking discreetly to another person who had needed assistance with personal care before supporting them to their room. Staff gave people ample time to respond when asking a question and listened to them and acted accordingly. People appeared to be comfortable when staff approached them.

Staff were more knowledgeable about people's preferences and life histories than we found during our inspection in September 2015. A member of staff told us they were working closely with relatives to develop memory boxes and information that could be used to plan care delivery and aid communication. Staff acknowledged that this was very much dependant on the relatives.

People told us they could have visitors whenever they wanted. Visitors confirmed they could visit regularly

and speak with their relatives in the lounge, their bedrooms or the dining room and in private if they wanted to. Visitors told us they were offered refreshments when they visited and were made to feel welcome.

Staff we spoke with all said they would be happy for a relative of theirs to be cared for at Oaktree Care Home. Those staff who had worked at the service for longer than six months commented that they would not have wanted a relative of theirs to be cared for at Oaktree six months ago.

Requires Improvement

Is the service responsive?

Our findings

The provider had responded to the concerns raised at the last inspection. They provided us with an action plan detailing how they were going to be compliant with the breaches of regulation. What they told us they would do they had completed, meaning people could be more confident that the staff would be responsive to their care and support needs.

People we spoke with told us they felt comfortable in raising a concern if they needed to with staff or the manager. Relatives and visitors said they were aware of the complaints procedure and would be prepared to make a formal complaint if necessary. However, most said they would feel happy to discuss things as they occurred with whoever was in charge.

During the inspection a relative raised concerns with us, which they told us had been directly reported to the manager on the 15 February 2016. When we reviewed the log of complaints there was no record of this complaint. We were also aware of two other complaints that had been given to the manager to investigate from us and the local safeguarding team since they had been in post. There was no record of these complaints on the log. The last recorded complaint was in April 2015 which related to the noise of the call bells. We were also aware of relatives and professionals raising concerns about people's care in August prior to the last inspection. There was no record of these complaints on the log. The manager could not give any explanation about the lack of recording. However, assurances were provided that the complaint raised on the 15 February 2016 was being investigated.

We found that where people had raised concerns these were not recorded and the provider could not evidence how these had been responded to. This was a breach of regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Receiving and acting on Complaints.

People had access to call bells to summon assistance from staff. These call bells were linked to pagers carried by staff and a visual display which told staff where the call was coming from. During our inspection call bells were regularly answered. However, we heard one person calling out for help. This person needed assistance and could not reach their call bell as it had not been placed within their reach.

People told us, "I don't usually have to call, staff are always popping in and out"; "I am quite safe, I have no worries, I have a buzzer but very rarely use it, they would come quickly if I did". For those people that were unable to use their call bell, regular checks were completed depending on the risks to the person. Some people were checked every 15 minutes, half hourly or hourly. These checks were completed throughout the day and night with records maintained.

One person and their relative told us how they had fallen in January 2016 and had remained on the floor with injuries for some time. This person said, "It frightened me when no-one came. I was on the floor for about 40 minutes". Their relative said, "I think it may have been less time but it would seem longer when you're the one on the floor". The provider had since given the person an emergency call bell pendant to wear to prevent a reoccurrence of this. We spoke with the staff member who attended the person when they

fell. They said, "I think it could have been about 15 or 20 minutes that (Person's name) was on the floor". The present call bell system did not allow the manager to monitor when the call bell was activated and when staff attended to the person. The manager and a senior manager said they were looking into how this could be done.

We received some concerns prior to Christmas in respect of how a person had been admitted to hospital without any information to enable the hospital staff to support the person safely and responsively. In response the manager had devised a check list for staff to follow prior to a person being admitted to hospital. This included a summary of the person's support needs, their medicine record, toiletries and spare clothing. Staff told us about the new checklist and that they had to photocopy information they sent with the person. This now meant people could be confident that when they transferred between different care settings information had been shared to ensure they were supported in a consistent manner. This is important when a person may be living with dementia as they may not recall how they were supported.

People were being provided with a structured plan of activities. These were provided by two activity co-ordinators. The manager told us they were in the process of employing a further activity co-ordinator so this could be provided over seven days including some evenings. There was a varied programme which included quizzes, arts and crafts, reminiscence discussions, chair aerobics exercise sessions, card games, gardening, baking, and bingo. In addition to the group activities the activity co-ordinators were spending time with people on a one to one basis. Whilst it was evident that there had been an increase in activities on Primrose, people on Bluebell felt they did not receive the same level of activities on a one to one basis as people experienced on Primrose. A relative told us their family member preferred one to one activities and these were rarely offered, and she particular liked quizzes. Records were maintained of the activities people took part in. It was noted this person in particular had few records of activities being completed with them.

Since the last inspection, staff on Primrose had obtained a variety of sensory materials including soft cuddly animals, dolls and twiddle muffs to give a sensory experience. Twiddle muffs are a knitted muffle mitt that contain different items sown on to them to enable the person to get a sensory experience. People were observed using these and taking an active interest in the items. Staff were observed engaged in conversation with people about the items attached to the twiddle muff.

External entertainers visited the home to provide music events at least weekly. People told us that the planned activity which was a drumming session had sadly been cancelled on the day of the inspection. Instead the activity co-ordinator had organised a short exercise session for people living on Bluebell. Once this ended people remained in this area chatting amongst themselves and with one of the inspection team. People appeared lively and enjoyed a sing along session which had been instigated by one of the people living in the home. People seemed both comfortable with the staff and each other.

A hairdresser visited the home once a week and the local church provided holy communion on a monthly basis. The manager told us it was important for people to continue to be part of the local community and the local community to be part of the home. The local library visited regularly providing people access to their facilities. The local cub pack visited the home to provide people with a 'camp fire sing session'. Links were also being built with a local heritage group who had recently visited bringing in old photographs of the local area.

Since our last inspection, the staff had developed a daily news sheet 'the daily sparkle', which was circulated to people living in the home. People spoke positively about this. One person told us they assisted in the stapling of the pages of the news sheet together and in the distribution. This kept people informed about what was going on in the home and the local area.

People had their needs assessed before they moved to the home either by the manager or the unit manager. Information had been sought from the person, their relatives and other professionals involved in their care. Information from the assessment had informed the plan of care. People had a care plan covering all areas of daily living. This included personal care, eating and drinking, sleep, hobbies and interests and any risks associated with their care or medical conditions. The care documentation included how the individual wanted to be supported. For example, when they wanted to get up, their likes and dislikes and important people in their life. These were reviewed on a monthly basis by the nurses and care staff.

Only one person we spoke with had actually seen and read their care plan. People told us they could not recall being involved in any care reviews. However they appeared to be happy about the way they were being cared for. They told us they were able to decide when they got up, when they went to go to bed and how they spend their day. A relative told us they had recently been involved in a care review. They said it was quite quick as there had been no changes.

Care plans had been updated and put into the new corporate care planning format. The unit manager told us this work was still in progress to ensure it was current to the person and some documentation had still to be moved over to the new format. Significant improvements had been noted in the care planning process for people living on Primrose. Information was more logically recorded demonstrating how the staff were supporting people. Daily records were being completed on how people were supported by the care staff. This enabled staff to monitor the well-being of people and any changes in respect of care delivery.

Since the last inspection the manager and staff had introduced a new system to ensure people's care needs were reviewed and monitored in more person centred way. 'Resident of the Day' is an initiative that helps care staff to understand what is important to each person and to review in depth what would make a difference to them. Staff told us the named person or persons' care needs would be reviewed and discussed during handover and with the person and their relatives. There would be an opportunity for the cook to meet with the person to discuss food likes and dislikes. Staff would make an extra special effort to spend time with the person and complete any monthly monitoring. Staff said this had been a positive experience for the person and ensured staff were kept informed of any changes and enabled them to get to know the person better. Records were shared with the manager so they could monitor any changes.

Requires Improvement

Is the service well-led?

Our findings

Since our last inspection a new manager had been appointed. This was because the previous registered manager had resigned shortly after the inspection in September 2015. The new manager commenced in post in October 2015, in addition a new deputy was appointed to support the manager with various aspects of the running of the home. The manager had not submitted an application to the Care Quality Commission to register with us. This process enables us to judge whether the manager has the necessary skills and knowledge to be the registered manager. There is a condition of registration that the Oaktree Care home has a registered manager. Whilst the delays in applying had been explained to us, the service was in breach of their registration with the Care Quality Commission. Whilst we will not be taking action at this stage an application must be submitted within a reasonable timescale.

The provider submitted an action plan detailing how they were going to ensure compliance with the requirements from the inspection conducted in September 2015. The manager and the staff were able to demonstrate the actions they had taken to address the breaches in regulation. The breaches found at the last inspection had now been resolved. However, the actions taken now have to be sustained and embedded into the culture of the home to ensure ongoing improvement. This included the ongoing recruitment of staff.

The manager told us they were planning to develop specific roles such as dementia and dignity champions to act as role models for staff and to encourage further improvement. They had been unable to source appropriate training within the organisation for these specific roles. They were now liaising with the local council's training department and external training providers to enable specific members of staff to be trained in these areas.

After the inspection in September 2015 we served a notice of proposal to stop admissions to the dementia floor which is now called Primrose. This had been adopted and the provider must not admit people to Primrose without the authorisation of the commission. This was because of the levels of concerns we found during the inspection in September 2015. This will now be kept under review in relation to the ongoing improvements that had been noted during this inspection.

We served a warning notice at the last inspection in respect of the previous registered manager and provider not notifying us of important information. Notifications tell us about significant events that happen in the service. We use this information to monitor the service and to check how events have been handled. The new manager had reported information to us as required this included information about allegations of abuse, any unexpected and expected deaths, serious injuries and any authorisations in respect of the Deprivation of Liberty Safeguards (DoLS).

We checked various trackers the new manager had introduced since the last inspection. This included safeguarding, deprivation of liberty safeguards and the log of incidents and accidents. This showed us the manager had informed us where necessary. There was a clear audit trail of what action the manager had taken including when this had been reported and who to. The unit managers of Primrose and Bluebell were

aware of the required reporting and the process. Compliance had been demonstrated in respect of this breach of regulation.

Complaints were not being recorded to enable the manager and the provider to review and look for any themes and learning. There had been a number of complaints raised by relatives and health care professionals prior to the inspection in September 2015 and there was no record of these on the complaint log. This meant we could not be assured that the complaint process was effective and the provider was not able to keep track of any complaints made.

People told us their views were not always sought through a survey with many stating they could not ever remember being asked to complete one. The manager told us paper surveys were no longer used and people and visitors were able to electronically input their feedback which was sent directly to the provider. There was an IPAD available for people and their relatives in the foyer to complete the survey. This may benefit from a review as people living in the home might not be aware of this or know how to use the system.

The manager was able to show us how information from the surveys was fed back to the home. There had been ten completed surveys since November 2015 and February 2016. Relatives, visitors and people had responded to 12 questions about the care and support that was in place. Everyone said their relative looked well cared for, 90% said their relative was happy to be in the home, 80% said they would recommend to a friend and 20% extremely likely and everyone said the staff had treated the person well. Activities and food did not score as well. 50% said there were sufficient activities, 20% said sometimes and 30% said do not know. The manager was aware this was an area that required some improvement with a further activity person being recruited. However, we saw significant improvements since our last inspection in the structure of activities and how this was being delivered. In respect of food there were mixed messages with 50% saying their relative had enjoyed the food and the other 50% sometimes.

Relatives confirmed they had been invited to meetings about the service. Minutes had been sent to them about the discussions. There had been two meetings since our last inspection. The manager told us the last one had not been as well attended as the first. Relatives had been informed about the improvements that had been made to the service.

Staff confirmed regular meetings were taking place. Staff were consulted about how the service could improve and the actions that were being taken to address the shortfalls at the last inspection. Minutes were maintained of the discussions and any actions that had been agreed.

Staff spoke positively about the new manager, deputy manager and the unit managers. They told us they felt better supported and there had been a number of improvements in the service which had a positive effect on the morale and the way staff supported people. Comments from staff included, "(Manager's name) has been fantastic since day one", "Management is great, they want the best for 'residents", "Six months ago there was no organisation. The structure, management and communication is much better now" and, "There has been a big improvement under the new management".

During the last inspection it was noted that the culture in the home was not person centred and focused on tasks. We observed that this had changed especially on Primrose. Staff were more attentive to people and they had a better understanding of dementia and how this impacted on people. One staff member demonstrated this person centred approach by saying, "They don't live in my workplace, I work in their home".

Since the last inspection, the provider had introduced a new role to enable promotion for care staff. In

addition to the senior care staff the provider had introduced the role of a care home assistant practitioner (CHAP). There was a CHAP on Primrose, they were able to assist with medicine administration, writing care plans, reporting directly to the safeguarding team, liaising with GPs and promoting dignity in the workplace. Specific training had been developed for this role over a twelve week period. The management spoke positively about this role and how this had relieved the pressure on the nurses and offered consistency for people. The manager was planning to offer this to other care staff. They were considering extending this to night care staff where it was acknowledged there was a higher use of agency nurses working in the home. The idea was not to replace nursing staff but to compliment and work alongside them.

The manager told us they or the deputy manager completed a daily walk around which included looking at the environment, people's care records and speaking with staff, people who use the service and their relatives. They told us they used an electronic device to record the information, which was then shared with the provider. We asked how they could review the information and share this with us. They were able to show us how the system worked and where shortfalls were found how these were addressed. The deputy manager told us they tried to complete the daily walk around at various times of the day.

The manager told us each morning a meeting was held with heads of departments including catering, housekeeping, unit managers, the deputy manager and the manager. The purpose was to look at any risks within the service in relation to staffing, people who were unwell or needed more support and to keep staff informed of matters relating to the running of the home. This ensured there was good communication throughout the home and enabled the manager to be kept informed of any concerns.

A representative of the provider told us weekly risk telephone meetings were held with all home managers enabling them to discuss any known risks such as staffing. This enabled the provider to plan for any foreseeable emergencies and plan appropriately. An example was given where additional staff were redeployed to Oaktree Care Home over the Christmas period as another service had surplus staff.

As part of the provider's action plan we were told there would be ongoing support from the organisation's dementia specialist team. Staff confirmed this had been in place but this had been withdrawn in January 2016. Staff told us the specialist team had offered guidance in respect of supporting people with dementia, mental capacity assessments and care planning. Staff told us they had found this very beneficial in improving the quality of the care to people living on Primrose.

Staff on Bluebell the nursing floor told us they had not received the same level of support in their area and felt that they too could have benefited from more resources such as training and management oversight because they felt standards in this area had slipped. Comments included, "We're more rushed than we were and don't have as much time for people", "It's really hard, I understand the emphasis needed to be on improving upstairs but we need extra help too" and, "We feel neglected compared to upstairs". This had been echoed by visiting health care professionals. The manager and the unit manager were aware of this and were in discussion on what improvements and support could be done to boost both staff morale and ensure standards did not slip further.

Support continues from the regional operations manager and the resident experience support manager. They visit weekly to monitor the service. Records were maintained of these checks and where any shortfalls were noted an action plan was developed. When we inspected in September 2015 there were numerous actions that remained outstanding from these visits. The new manager along with the resident experience support manager had reviewed and completed all the outstanding actions.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to ensure there was sufficient information to guide staff on as an when required medication. Systems were not in place to check the amount of medicines held in the home. This meant the people could not always be assured they were receiving their medicines safely and consistently. Regulation 12 (1) (2) (a) (g)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints The provider had failed to record complaints and demonstrate how these had been investigated. This meant people could not be assured there were systems to learn from any themes emerging from these complaints and that they were listened too. Regulation 16 (1) (2).