Laudcare Limited

Oaktree Care Home

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This inspection took place on 22 and 24 February 2017. We carried out this inspection because we found two breaches of regulation at the last inspection in February 2016. The provider sent us an action plan which we reviewed during this inspection.

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 was 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 were 47 people living at Oaktree Care Home when we inspected.

There was a registered manager in post. 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.'

We found at our last inspection in February 2016 there were some areas the service had to improve to ensure people were safe in respect of the management of medicines and the recording of complaints. Improvements in these areas were noted. The registered persons had taken appropriate action to address these areas.

It was evident that since our last inspection the service had sustained and continued to make improvements where required. Feedback from people, their relatives and visiting health professionals was positive about the care and support that was in place. The service was well led with good leadership from the registered manager and the unit managers in ensuring these improvements continued. Staff told us they were working as a team to support people in an individualised way. Feedback from visiting health and social care professionals provided us with evidence that the staff understood and knew the people they were supporting well. This was echoed by people who used the service and their relatives.

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's rights were protected and where restrictions were in place this was done with the appropriate authorisation involving other professionals. This was kept under review.

Systems were in place to ensure people were safe including risk management, checks on the environment and safe recruitment processes.

People were receiving care that was responsive and effective. 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. People's health care needs were being met. Other health and social professionals were involved in the care of the people living at Oaktree. Referrals were made in a timely manner for people where required.

People's nutritional needs were being met. Where there were risks to people there were clear plan of care in place, additional monitoring and good communication between the care and catering staff.

Staff were caring and supportive and demonstrated a good understanding of their roles in supporting people. Staff had received training and support that was relevant to their roles. This had included all staff at all levels in the working towards an accredited training programme for supporting people with dementia. 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.

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. The registered manager knew that this was an area that needed improvement and was activity recruiting to the vacant activity posts. People were treated with dignity and respect and were involved in decisions about their care.

People's views were sought through care reviews and electronic surveys. Systems were in place to ensure that complaints were responded to, and learning from these was taken to improve the service provided.

The provider had introduced systems to assess, monitor and improve the quality of care. This meant the provider and the registered 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 registered manager had worked with the unit managers, staff and people to develop an action plan to address these.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

People were safe from harm because staff reported any concerns and were aware of their responsibilities to keep people safe.

Risks to people were being assessed and monitored. Where risks had been identified, management plans were in place. Staff were provided with sufficient and up to date information, which assisted in keeping people safe.

Medicines were well managed with people receiving their medicines as prescribed.

Sufficient staff were available to meet the needs of the people. This was kept under review.

Is the service effective?

Good

The service was effective.

People could be confident that their healthcare needs were monitored involving other health and social care professionals.

People were supported by staff who knew them well and had received the appropriate training. 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'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 cared for with respect and dignity. Staff were knowledgeable about the individual needs of people and responded appropriately. Staff were polite and friendly in their

approach.

Staff knew people well and were able to tell us how people liked to receive their care. People were encouraged to be as independent as they were able.

People were involved in end of life discussions enabling the staff to provide care based on their wishes ensuring it was comfortable experience for them and their relatives.

Is the service responsive?

Good

The service was responsive.

People had been assessed and their care and support needs identified. Care plans were in place to ensure people received care which was met their needs, wishes and aspirations. Staff were knowledgeable about the people they were supporting. Care was tailored to the person.

People were supported to take part in activities in the home and the local community had a presence within the home. The registered manager was aware activities was an area that could improve.

There was a complaints policy and procedure in place. People and their relatives knew how to make a complaint if needed and complaints had been responded to.

Is the service well-led?

Good

The service was well led.

Staff felt supported and worked well as a team. The registered manager worked alongside the staff team to deliver and monitor the quality of the care to people. People, their relatives and staff spoke positively about the leadership of the home and felt listened too.

Systems were in place to review and improve the quality of the service. This included seeking the views of people who used the service, their relatives and staff on the running of the service and day to day care. The provider was taking an active role in supporting and monitoring the service.

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 22 and 23 February 2017 and was unannounced. The inspection team consisted of two inspectors, a pharmacist 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. 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 the information we had about the service. This information included the statutory notifications that the provider had sent to CQC. A notification is information about important events, which the service is required to send us by law. We reviewed the Provider Information Record (PIR). This is a form that asks the provider to give some key information about the service, tells us what the service does well and the improvements they plan to make.

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 and safeguarding team and the local Commissioning for Continuing Health. You can see what they told us in the main body of the report.

We looked at eight 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 registered manager, a senior representative from Laudcare Ltd, three nurses, six care staff, 15 people who used the service and nine relatives and visitors.

Good

Is the service safe?

Our findings

People told us they felt safe and were well supported by the staff. Comments included, "I feel very safe, there are kind people looking out for you", "There is nothing to make me feel that I am not safe, I see people about all day" and "I can speak to staff if I feel unsafe, but I am happy and safe here". Relatives confirmed that they felt people were safe. One visitor told us their relative was safe because the staff knew their relative well. Another relative told us, "If anything happens to mum, the staff will take the right action and keep us informed as a family". Staff described a team that worked together to meet people's needs in a safe way because there was good communication between staff. Where people were at risk this was communicated to staff through shift handovers.

We found that there had been improvements to the way medicines were managed since our previous inspection. People received their medicines in a safe way. We watched some medicines being given at lunchtime, and saw that people were asked if they needed any medicines that had been prescribed for them on a 'when required' basis, for example pain relief. There was information in people's care plans about their current medicines, and any guidance for administration if medicines were prescribed 'when required' so that staff would know when it was appropriate to give them if necessary.

There was no one who looked after their own medicines at the time of this inspection but there were policies in place to allow this if people wished, and after it had been assessed as safe for them to do so.

Medicines were given by nurses or senior staff who had received training, and had been assessed to make sure they gave medicines safely. There were clear records of medicines administered to people or when not given for any reason. This helped to show that people received their medicines correctly in the way prescribed for them. Care staff also recorded the application of creams or other external items. Medicines were stored securely. There were suitable arrangements and records for some medicines that required additional secure storage, and those needing cold storage.

People received a safe service because risks to their health and safety were being well managed. Care records included risk assessments about keeping people safe. 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. Other professionals such as speech and language therapists had been involved in advising on safe practices and equipment required. Staff described to us, how they ensured people's safety in all aspects of their care.

Staff confirmed there were sufficient hoists available in the home. The registered manager told us there were two moving and handling trainer and assessors working and supporting staff. Staff were checked periodically to ensure staff were assisting people safely and in accordance with the person's plan of care. 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 safety. 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.
People were kept safe by staff who understood what abuse meant and what to look out for. Staff confirmed they were trained and knew the signs to look out for in respect of an allegation of abuse. Safeguarding procedures were available for staff to follow with contact information for the local authority safeguarding team. The registered manager had reported appropriately any information of concern to the local authority and steps had been taken to reduce any further risks.

Sufficient staff were supporting people. This was confirmed in discussion with staff, people and their relatives. Staff told us any shortfalls in staffing were covered by the staff team and agency staff. People told us staff responded promptly when they used their call bell and there were always staff available to help them. Where people were unable to use their call bell regular checks were completed depending on the level risk. Staff told us this was usually every hour or more frequently if a person was unwell or particularly anxious. Records were maintained of these checks.

The registered manager told us agency usage had been reduced considerably in the last twelve months with ongoing recruitment of staff. We were told that the home was now fully staffed during the day however, recruitment was ongoing in respect of three vacant night posts. The registered manager told us staffing was kept under review taking into consideration occupancy and the needs of the people they were supporting.

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 and suitable staff were employed.

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. We noted there was a strong smell in a wet room on the ground floor. On further investigation, it was noted that the fabric underneath a shower chair was ripped which had allowed water to soak into the foam causing the odour. This was removed promptly by the registered manager.

People, relatives and health and social care professionals confirmed the home was cleaned to a good standard and there were no lingering odours. One person said, "It is very nice and clean. The cleaners are very good" and another person told us, "The cleaning is brilliant, I am very happy with all they do". The registered manager told us daily walk arounds were completed by a variety of staff, which included checking whether the environment was clean and free from odour.

Good

Is the service effective?

Our findings

People spoke positively about the staff that were supporting them. Relatives confirmed they were kept informed about any changes and were involved in care reviews. One relative told us they were meeting with some health professionals and the staff to discuss some changes that had recently taken place with the care of their parent. Another relative told us they had been kept fully informed about the care of their mother with regular communication from the staff and their relative's GP. Another person told us they had been in the home for twelve years and they could not fault it, stating, "It is lovely".

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. Records were maintained of health care appointments, including any treatment and follow-ups. 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. Feedback from visiting professionals was positive. They had noted that there had been improvements over the last 18 months, which had been sustained. Feedback included, "Staff know their patients well, and contact us appropriately", "Nurses are much more pro-active with such things as weight loss, patients' well-being and mental health" and "They seem to understand and know the needs of all the patients and respond appropriately". One GP said that the monitoring of blood pressure and temperatures when a person was unwell could be improved with this done throughout the day and not just once a day.

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 service and supports people enabling them to remain in the care home. People also had access to a podiatrist and opticians where required. People confirmed they had access to other health professionals including a dentist 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. Nurses confirmed they had attended a training update session on wound care management. The registered manager had systems in place to monitor the treatment and healing process and was provided with regular updates from the unit managers in respect of those people that had an acquired pressure wound.

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. 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. Staff had received training in the MCA and DoLS.

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 registered 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 unit managers told us the registered manager was proactive in chasing up the process of renewals and this was started one month prior to the expiry date. Where an authorisation was in place for a person, the Care Quality Commission had been informed.

Some people had chosen to make advanced decisions about the care they did not want to receive in a medical emergency or at the end of their life. Some people had a do not attempt cardio pulmonary resuscitation (DNACPR) stored at the front of their care file. A DNACPR is a decision made when it is not in a person's best interest to resuscitate them if their heart should stop beating suddenly. We looked at four DNACPR orders and found that the decision had been discussed with the person and a close relative. Information was available for staff to find this quickly on an information sharing board in the nurse's office, which identified those people who had a DNACPR order in place. This meant staff could find this information quickly in the event of a medical emergency.

People told us they were involved in making decisions on how they wanted to be supported. Staff were observed seeking people's consent prior to any care was delivered. Staff understood the importance of people being involved and clearly described how they supported people. For example, in one person's care plan it clearly stated that when speaking with them make sure they have their hearing aid.

People's nutritional needs were being met. Where people had been assessed as being at risk of malnutrition, clear plans of care were in place. 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 registered 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. Where people had been at risk at previous inspections in relation to weight loss this had been resolved with improvements noted.

There was good communication between the care and catering staff. People were visited by the catering staff to discuss their likes/dislikes and any specialist requirements on a regular basis. This started when a person first moved to the home as part of the assessment process. Where people's needs had changed this was discussed with the catering staff.

We observed people at lunchtime on Primrose and Bluebell. Staff took care to welcome people to the dining room and assist them to a table of their choosing. People were offered a choice of what they would like from

two main options. Where people did not like either then further options were offered. People spoke positively about the food that was available to them. Comments included, "The food is very good. I don't like fish so the chef prepares me something else", "It's very good food, great sausages and lovely fish and chips" and "There are no problems with the food. I should know I was a cook with my own catering business". Another person told us they were a vegetarian and their dietary needs were being met. A group of people we spoke with told us they really enjoyed the food, the variety, the homemade cakes and cooked breakfasts.

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.

However, we did observe a new member of staff supporting a new person and they were unaware they could move the sensor mats which were situated by the person's bed. This would have enabled them to be seated correctly. We pointed this out to a senior member of staff who promptly supported the member of staff and the person to make sure it was a better experience. More time was allocated to the new member of staff on the afternoon as part of their induction. Staff responsible for allocating roles also reflected on the experience and recognised it would have been more beneficial for the new member of staff to spend time shadowing more experienced staff.

Staff received training so they knew how to support people in a safe and effective way. Staff felt they were provided with appropriate training and were competent in the tasks they carried out. They told us their training needs were discussed during their individual supervision meetings with their line manager. Staff completed a comprehensive induction, which included spending time with experienced members of staff, completing a range of eLearning and opportunities to read care plans, key policies and procedures. Staff also completed the care certificate. This is a national programme of induction for staff who are new to care.

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 together and shared their knowledge and expertise. Staff working in the dementia area of the home were mental health nurses and general nurses worked on the ground floor. It was evident staff shared their expertise and worked together to improve outcomes for people. For example, if they were concerned about a person's medical condition/health then they could seek advice and support from a general nurse working downstairs. This worked the other way with the nurses downstairs seeking advice on areas such as mental capacity, best interest and meeting the needs of people living with dementia.

Staff confirmed they received supervision with their line manager. Supervision meetings were where an individual employee met with their manager to review their performance and any concerns they may have about their work. The supervision matrix showed that not all staff were receiving supervisions in accordance with the expectations of the organisation. The registered manager told us they were addressing this with individual supervisors. Nurses told us although they did not receive formal supervision the registered manager was always available to discuss any concerns or share ideas.

Staff meetings were held bi-monthly for each of the units and the catering and domestic staff. These provided the opportunity for staff to discuss a range of issues and to keep up to date with information about the people who used the service. There was also a daily meeting where the registered manager, unit managers, head of catering and maintenance met to discuss any specific areas of concern. The information from these meetings were cascaded where relevant to other members of staff working in the home. This showed there was effective communication systems in place.

Oaktree Care Home is a 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. There is a lift enabling people to access the first floor.

There was outside space, which people on the ground floor could access independently. The registered manager told us work on the garden was still outstanding from the last inspection. It was hoped this area would be levelled and made 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.

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. The registered manager told us people had been supported to choose the colour scheme for their bedroom. One person had gone to a local store to choose their own wallpaper supported by staff whilst others had been shown samples and colour charts.

New patio doors had been installed in two of the lounge areas leading to the garden area, which had enhanced the look and security to this area. Since the last inspection, a new medicine clinic and nursing office had been developed by reconfiguring two bathrooms. A new wet room had been installed on the ground floor. Staff spoke very positively about this. Ongoing decoration was taking place on the day of the inspection with the hallway and communal areas being painted on Primrose.

There were still some outstanding actions such as making the ends of corridors in Primrose more interesting for people living with dementia by providing themed areas such as a garden corner. Staff told us they were planning 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. This was outstanding from the last inspection.

Good

Is the service caring?

Our findings

People spoke positively about the care and support they received from staff. Comments included, "They are very good carers, I can do most things for myself but they are there to help me if I need it", "We are very lucky, the staff and nurses if they can do it they will do it", "From top to bottom [building] they are all lovely and very good", "I see different staff from an agency sometimes but they are all ok, they are definitely very good carers", "'If I ask staff they will do anything for me", and "I think the carers are wonderful here. The staff are always asking how you are". Relatives also spoke positively about the care and support that their loved ones received.

People told us they liked the staff that supported them. Throughout the day, we observed all staff, from housekeeping staff, the cook and the care staff spending time with people engaged in conversations. Staff knew they needed to spend time with people to be caring and have concern for their wellbeing. Staff told us there was sufficient staff to enable them to spend time with people. Staff told us personal care was not rushed enabling staff to spend quality time with people.

We observed staff knocking on doors and waiting for people to confirm they could enter. Staff closed bedroom doors when supporting people with personal care. Staff were heard asking permission to assist people, offering reassurance and explaining to them what they were doing.
Relatives confirmed that when personal care was delivered this was completed in a way that maintained their relative's privacy and dignity. This demonstrated staff respected the person's rights to privacy and their involvement. One relative said, "The staff are very attentive. The staff are all kind with mum, they explain what they are doing and offer reassurance when assisting with any personal care". A person told us, "It's a really nice home, the staff are kind. I like to spend time in my bedroom keeping in touch with friends and watching television". They told us they were encouraged to join the others but when they declined, their decision was respected.

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. Staff were addressing people by their preferred name when talking with them, using appropriate volume and tone of voice. One person preferred to be supported by a male care staff with their showering arrangements. A member of staff confirmed this person's wishes were respected. Although they worked upstairs they would support this person regularly if there were no male carers working downstairs. Another person liked to eat during the night and staff ensured their fridge in their bedroom contained their preferred snacks. Another person had a particular sweet tooth and staff had ensured there were sweets and cake within easy reach as this person had very limited mobility. This showed the staff were accommodating people's wishes.

Care plans included what the person could do for themselves and where they needed support. This meant people were supported to maintain their independence. One person told us, "I can do most things for myself; the staff are there to help me if I need them". One person observed was becoming upset because they could no longer walk. Staff provided the person reassurance and explained the progress they had recently made in being able to transfer and no longer required the use of a hoist. The staff member showed

genuine warmth to the person, which raised their spirits.
People looked well cared for. This included ensuring people had their glasses, some ladies had painted nails and others had jewellery that matched their outfits. People's hair looked clean and groomed. People's care plans included what was important to them.

One person complained they were feeling cold, staff responded promptly returning with two cardigans enabling the person to choose which one they wanted to wear. The staff member's approach was very person centred and promoted involvement of the person enabling them to choose what to wear. Another person told us, "The staff always ask me what I would like to wear, showing me different items of clothing".

Staff described people in a positive manner and they were knowledgeable about people's life histories and important family contacts. We spent some time in the lounge and dining areas observing interactions between staff and people. Staff were respectful and spoke to people kindly and with consideration. Staff were unrushed and caring in their attitude towards people. People were addressed by their chosen name. One person was anxious and calling out. Staff were attentive in reducing this person's anxiety by spending time looking and talking about a photograph album they owned. This formed part of the person's care plan as a means to alleviating feelings of anxiety. Another person called out for assistance. Staff were seen responding promptly and returning with a cup of tea and biscuits. These acts showed staff were caring in their approach and were person centred.
People were able to maintain contact with family and friends. There was an open visiting arrangement. People confirmed they could entertain their visitors in the lounge areas or in their bedrooms. Relatives told us they were made to feel welcome and were offered refreshments. Relatives were able to bring in their pets if they wanted.

Information was made available to people about the service. This included a statement of purpose, a brochure about Oaktree Care Home and what it had to offer including information about how to raise a complaint. These were available in the main entrance of the service.

People had been asked about their end of life wishes and how they wanted to be supported and who needed to be contacted. The staff would liaise with other professionals including palliative care specialists and the person's GP to ensure all equipment and appropriate pain relief was in place to support the person.

We were told relatives could stay and visit for as long as they wished during this period. A relative confirmed they could spend as much time in the home and the staff had been very attentive ensuring family members were comfortable and had all they needed. They told us the staff had all been very kind and they could not fault the support that had been in place for their relative and the family. One person told us, "When my friend passed away here staff closed all the doors and lined up as the coffin was carried down the corridor they were so respectful and it meant a lot to us".

People were supported to make advance decisions to refuse treatment or appoint someone with lasting powers of attorney, if they wished to do so. Information in people's care plans clearly recorded who they had appointed where relevant and their legal responsibilities in respect of what decisions they could be involved with. The registered manager had obtained copies of the documentation and was aware of their responsibility to include the person's representative in any decision making.

Good

Is the service responsive?

Our findings

People told us the staff were responsive to their care needs and supported them promptly when they called for assistance. People told us call bells were answered promptly. The registered manager was able to monitor call bell response times. Some people told us there was not always enough activities taken place especially when the activity co-ordinator was not working. The activity co-ordinator told us they tried to see everyone during their working week and left ideas for staff when they were not working. The registered manager was aware that this was an area that could improve and was actively recruiting to the two vacant activity co-ordinator positions and was working on an action plan.

On the first day of our inspection there were no organised group activities taking place as the activity coordinator was not working. The activity co-ordinator told us they completed a combination of group activities and one to one sessions where this was preferred. An activity was organised on the second day. Different hats were worn by the activity coordinator to promote communication in small groups and with individuals that had chosen to remain in their bedrooms.

External entertainers visited the home to provide music events at least a once a month. A hairdresser visited the home weekly and the local church provided holy communion on a monthly basis. Links with the local community had continued with local school children, cubs and brownies visiting enabling the community to be part of Oaktree. People also told us about a choir that had sang to them recently. The registered manager also told us about how some people had been supported to attend the local community centre to watch a theatre production. The registered manager said this had been very successful and would be arranged again in the future. A mobile library visited the home every fortnight. The registered manager told us they now had a minibus and they would like to organise trips for people in the summer. Presently it was being used to take people to healthcare appointments.

People had their needs assessed before they moved to the home by the unit managers or a nurse. 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. We noted some minor discrepancies in some of the care documentation which had been addressed by the second day of the inspection. This included conflicting information about a person's choking risk assessment. This was because in one part of the documentation the person had a medium risk and in another a moderate risk. The other related to medicines to reduce anxiety there was no clear plan to guide staff on the best practice.

We removed an imposed condition on the provider's registration in July 2016 to enable them to admit people to the dementia unit. This was because the service had demonstrated sustained improvements which had removed the risks to people since the inspection in September 2015. The registered manager and a unit manager told us they had a clear plan in respect of filling the vacant beds on the dementia unit. They

ensured this was done slowly to enable staff to get to know each person and allow the person to settle into life in the home before admitting a further person. They told us this was important to ensure they could meet the needs of the new person and the existing group of people on Primrose. There were 11 vacancies, seven on Primrose and four on Blue Bell. In addition there was an area of the home on the first floor which was not being used which could accommodate a further 18 people. The provider was exploring options with local commissioners on how this area of the home could be used for the local population. It was evident there was a robust process to ensure there was a smooth transition for people moving to the home.

People had information in their bedrooms such as daily charts for recording positional changes, food and fluid charts and hourly checks. The records were completed at the appropriate intervals. However, fluid charts would benefit from being totalled periodically. This would ensure people were receiving sufficient fluids throughout the day or where this was not the case staff could offer additional drinks. Staff told us this was always discussed at handover if a person was not eating or drinking very well so staff could be more vigilant. People also had booklets entitled 'My Journal' in their bedrooms. The aim of 'My Journal' was to provide staff with life histories, likes and dislikes and information about important people in their life. This enabled staff to provide person centred care which reflected people's preferences and aid communication.

Staff were meant to complete an entry at least weekly in each person's journal or when a specific incident had occurred. The registered manager told us after completing a recent audit this was not happening and now the staff were expected to record daily. This had been communicated to staff via handovers, the communication book and through team meetings. There were still some shortfalls in the daily recording but this was being monitored by the unit managers and the registered manager. One of the unit managers told us they would now introduce a daily check to ensure this was taking place in response to us finding some gaps in the recording.

Daily handovers were taking place between staff. Staff told us this was important to ensure all staff were aware of any changes to people's care needs and to ensure a consistent approach. Staff described how they worked as a team to enable them to respond to people's needs and stated that communication was an important factor. They said systems of communication had continued to improve since the last inspection. Communication books had been put in place to ensure staff that had not worked in the home for a period of time had an opportunity to keep up to date with any changes. This was used as an aid memoire at each handover to ensure information was shared.

The registered manager and staff had continued with a system that they had introduced prior to the last inspection. This was to ensure people's care needs were reviewed and monitored in more person centred way. 'Resident of the Day' was an initiative that helped 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 chef 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 registered manager so they could monitor any changes.

Health and social care professionals told us prior to the inspection they felt the service was responsive to people's individual needs and care was delivered in a person centred way. One example they gave was when they were involved with a person who was very challenging and had become very aggressive towards staff. They stated the staff managed to identify that the behaviour was triggered by dental pain. Staff proactively liaised with the GP to put in place pain relief measures and arranged an emergency dental appointment.

Another example was where a person was regularly refusing to eat what was on offer and in response the staff supported the person to go to the shops to purchase food of their choice. This showed the staff were responsive and care was tailored to the person.

During the last inspection we found that where people had raised concerns these were not always recorded and the provider could not evidence how these had been responded to. The provider had made the necessary improvements. The records included the nature of the complaint, the investigation and the outcome. People and their relatives told us they were confident their concerns would be listened and action taken to address these.

There was a complaints policy and procedure. The policy outlined how people could make a complaint with a timescale of when people could expect their complaint to be addressed. We looked at the complaints log. We found people had been listened to. The records included the nature of the complaint, the investigation and the outcome. We found complaints had been responded to within the agreed timescales.

People told us they were aware of how to make a complaint and would have no hesitation in going to any member of staff or the registered manager. Comments included, "I have nothing really to complain about. If I needed to I would speak to carers or the manager", another person told us, "I have no complaints, there is always someone to talk to if anything happens."

Good

Is the service well-led?

Our findings

The registered manager had worked at Oaktree Care Home since October 2015 and been registered with CQC since June 2016. There had been up until recently a deputy manager in post but they had been seconded to another home owned by the provider. The registered manager told us the deputy role in the interim was shared by the two unit managers. The provider recognised this was not ideal and was looking at options to employ a new deputy which would assist the registered manager in their management responsibilities.

The registered manager was supported by the regional management who carried out visits on a regular basis. The registered manager was also supported by the provider's designated health and safety team, HR department, quality facilitators and others as required. A dementia care facilitator was supporting the home on the day of the inspection and was working with individual members of staff as required. The service was working to implement the dementia care framework. This is an accredited programme to improve and embed good practice in supporting people living with dementia. It is a personalised approach to care with everyone being involved from managers to housekeeping staff. All staff were receiving training in this approach.

The registered manager and a member of the care team had also been to visit another care home in the local area who were supporting people living with dementia. Feedback from their visit was positive in respect of how people were being supported. They told us how they were planning to share some of the good practice to improve the quality of life for people in Oaktree Care Home. Such as recruiting volunteers to help with regular activities and to develop areas of interest with rummage boxes that would help communication with people who had dementia.

The provider told us prior to the inspection there had been an error on their part in the expiry dates that triggered refresher courses for mandatory training. These were not set in line with their current policies and affected all services operated by the provider. They provided us with an action plan on how this was going to be addressed. The registered manager was aware of the action plan to ensure staff completed annual refresher training in allergen awareness in care, Mental Capacity Act, infection control and safeguarding. This information had been cascaded to the staff as they were aware of the training they needed to complete. Prior to this error the home was 95% complaint with training. Once the error was spotted their compliance level dropped to 79%. However, within five days this had been rectified with the service now being 85% compliant. This showed that the provider and the registered manager had responded promptly to the shortfalls in training. It also showed there was learning across the whole organisation and that the provider was open and transparent with the Care Quality Commission.

From this inspection it was evident that there was a strong leadership presence within the home which had meant improvements had been sustained. Staff described a positive culture in the home, including a team that worked together to meet people's needs. Staff told us the registered manager was open and transparent. Comments included, "This is the best manager Oaktree has ever had, she will always come and help and if you have any query or concern, you know it be will be dealt with there and then", "(Name of

Manager) shows good leadership, she motivates and keeps the team focussed and allows the staff to shine". Three staff made a particular point of telling us about how the registered manager had made a real difference. Comments included, "It is just brilliant here now", "It is good place to work and live and people are the focus, the atmosphere has completely changed," and "It is a good place to work, there are still improvements to be made but we have come a long way".
A relative told us, "I have no concerns, but if I did I know these would be dealt with by the manager", and another relative told us, "It is excellent care, I have no complaints". People told us they knew who the registered manager was and she had a good presence in the home. Feedback from health and social care professionals also commented positively about the management of the service and the improvements in communication, the general atmosphere in the home and the staff being knowledgeable about the people they were supporting.

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 had been working in this role since the last inspection. 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 registered manager told us a further member of staff was completing this training as it had been very successful. The role was not to replace nursing staff but to compliment and work alongside them. Other staff were completing diplomas in care at various levels to enhance their skills and knowledge. One of the unit managers told us they were completing a qualification in leadership.

We saw a number of audits had been used to make sure policies and procedures were being followed and the quality of the service was monitored. We saw evidence of medication and health a safety audits. Staff completed medicines checks and audits to help make sure that medicines were managed safely. Any medicines incidents or issues were reported, dealt with appropriately and suitable actions taken if necessary to reduce the chances of them occurring again. This meant that the people were protected by the governance systems that monitored the quality of the service. The registered manager described how they used these audits and the surveys completed to improve the experience for people and improve the working conditions for staff.

The provider had introduced a system called "Quality of Life Programme" which enabled staff, visiting healthcare professionals, people and their visitors to provide immediate feedback on a daily basis electronically. Feedback was gained by people completing a survey on line using information technology. The registered manager explained that any information that required a follow up was sent to them and the regional manager so action could be taken promptly. The provider had introduced these to gather continuous feedback about all their services to enable them to look at any themes to aid learning across the organisation. These had replaced annual paper surveys as it was recognised there was a low percentage returned.

The registered manager told us they or the unit managers or a senior member of staff completed a daily walk around which included looking at the environment, people's care records and speaking with staff, people who used the service and their relatives. They told us they used an electronic device to record the information, which was then shared with the provider. A unit manager told us they tried to complete the daily walk around at various times of the day including nights.

The registered manager told us each morning a 'flash' 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.

The registered manager submitted a weekly update to the regional manager and reported on any accidents and incidents, safeguarding events, health and safety issues, complaints, staffing issues and issues regarding people's care. The registered manager attended monthly meetings with other registered managers and the regional manager. This ensured the provider was aware of how the service was being run. This was also an opportunity for the sharing of good practice and explore any common themes to any events that had occurred across the organisation.

Resident and family meetings were held every six months to discuss any changes to the running of the home, provide a time to listen to the views of people collectively and plan activities. Records were kept of these meetings. Discussions were held around the environment, decoration, staffing, activities and quality of the service.

All accidents and incidents were entered on to an electronic tracking system. At the end of each month the registered manager and the regional manager reviewed the information to look for any trends. They could analyse the number of falls or the number of events for a particular person. This enabled them to ensure the right care and support was in place.

The registered manager was aware of when notifications had to be sent in to CQC. A notification is information about important events which had happened in the home the service is required to send us by law. The CQC used information sent to us via the notification process to monitor the service and to check how any events had been handled.