Meridian Healthcare Limited

The Oakes Care Centre

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection of The Oakes Care Centre took place on 27 and 31 July 2017. We previously inspected the service on 11 April 2016; we rated the service Requires Improvement, at that time we found the registered provider was not meeting the regulations relating to dignity and respect, staffing and good governance. At this inspection we checked to see if improvements had been made and sustained at The Oakes.

The Oakes Care Centre is registered to provide care and support to older people. The home has a maximum occupancy of 60 people. The home has a unit on the ground and first floor. On the day of our inspection 55 people were resident at the home.

The service had a manager in place, they had commenced their application to register with the Care Quality Commission (CQC) but the process had not yet been completed. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People told us they felt safe. Staff were aware of their responsibilities for keeping people safe and knew how and where to report any concerns. People's care plans contained a variety of risk assessments although we found some people's moving and handling documentation lacked relevant information, we spoke with the manager after the first day of our inspection and they took prompt action to rectify these matters prior to our return to the home the following week. There was a system in place to ensure the premises and equipment were safe.

Safe recruitment practices were in place. The manager was taking steps to improve the skill mix of staff in particular on night duty; they had also reviewed staffing numbers at the home following analysis of the accident statistics.

Medicines were not always managed safely. We have made a recommendation about the management of some medicines.

People who lived at the home felt staff had the skills they needed to meet their needs. Staff received regular supervision and there was an on-going programme of training for staff. The new manager was eager to ensure staff had appropriate skills and work was in place to further develop staff knowledge and skills.

Care plans contained evidence of mental capacity assessments and care records referred to acting in people's best interests but there was not always documentary evidence this process had been followed. Staff supported people to make their own choices and decisions and we heard staff asking peoples consent prior to them supporting people with care and support.

People were supported to have maximum choice and control of their lives and staff support them in the

least restrictive way possible; the policies and systems in the service support this practice

People told us they enjoyed their meals. We observed lunchtime and saw people were offered a choice of food and drink. People were also offered drinks and snacks between meals. People's nutritional risk was regularly monitored and action taken if required.

People told us staff were caring and kind. Throughout the inspection we saw staff spoke with people and supported them in a friendly and appropriate manner. Staff were aware of the need to ensure people's privacy and dignity were respected and we saw examples of this when we were present at the home. The manager had begun to encourage people to become more involved in the care planning process.

People spoke positively about the activities at the home. During the inspection the atmosphere on both floors was warm and homely. Films on the television and the music being played was appropriate to the listening audience.

People were assessed prior to their moving into The Oakes to ensure their needs could be met. Care plans were in place but they did not all contain a satisfactory level of information. Life history records were incomplete and a new system for staff to record people's daily care and support was not yet fully embedded.

Staff and people who lived at the home spoke positively about the changes being made by the new manager. There was a system of audits in place to ensure the quality of the service people received was continually monitored. Audits were completed internally and by senior managers external to the service. Although the governance system had not identified or rectified the issues we raised while we were completing our inspection. A monthly report completed by the manager ensured the area director and registered provider were aware of a number clinical indicators which enabled them to assess the performance of the home. Regular feedback was gained from staff and people who lived at the home.

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.

Medicines were not always managed safely.

People told us they felt safe.

Risk assessments were in place to reduce the risk of harm to people.

Robust recruitment practices were in place.

Is the service effective?

Requires Improvement

The service was not always effective.

Where people lacked capacity regarding specific aspects of their care, capacity assessments had not always been completed.

Staff received on-going supervision and training.

People were offered a choice of meals and drinks.

People received input from external healthcare professionals when required.

Is the service caring?

Good

The service was caring.

People told us staff were caring and kind.

People's privacy and dignity were maintained.

People were being encouraged to become more involved in their care plan.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care records were not always complete and lacked detail.

People were assessed prior to their admission to the home to ensure the home could meet their needs.

There were a range of activities available for people to participate in.

There was a complaints procedure in place.

Is the service well-led?

Requires Improvement

The service was not always well led.

There was a manager in post but they had not yet completed their registration with the Care Quality Commission.

There was a system of governance in place and audits were completed on a regular basis, although the audits had not identified and addressed the issues we raised during our inspection.

Regular meetings were held with staff and people who lived at the home.

The Oakes Care Centre

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 27 July 2017 and was unannounced. An unannounced inspection is where we visit the service without telling anyone. The inspection team consisted of three adult social care 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. The expert by experience on this occasion had experience of working in health and social care. Two inspectors also visited the home again on 31 July 2017. This visit was announced and was to ensure the manager would be available to meet with us.

Prior to our inspection visit we reviewed the service's inspection history, current registration status and other notifications the registered person is required to tell us about. Notifications are when registered providers send us information about certain changes, events or incidents that occur within the service. We contacted commissioners of the service, the safeguarding team and Healthwatch to ascertain whether they held any information about the service. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. This information was used to assist with the planning of our inspection and inform our judgements about the service.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

We used a number of different methods to help us understand the experiences of people who lived in the home. We spent time in the lounge and dining room areas observing the care and support people received. We spoke with six people who were living in the home, two relatives and a visiting health professional. We also spoke with the area director, home manager, deputy manager, three care staff, the well-being co-ordinator, maintenance person and three ancillary staff. We reviewed four staff recruitment files, six people's care records and a variety of documents which related to the management and governance of the home.

Requires Improvement

Is the service safe?

Our findings

Our inspection on 11 April 2016 found the registered person was not meeting the regulations in regard to staffing as there were insufficient numbers of suitably qualified, competent and skilled staff. At this inspection we found a number of improvements had been made.

There were systems and processes in place to reduce the risk of harm and abuse. Each of the people we spoke with told us they felt safe. One person told us, "Yes I do, that is the reason I am staying." When we asked one person if they felt safe they responded, "I have never felt otherwise." A relative said, "I feel [person] is safe and well cared for."

Staff were knowledgeable about what may constitute abuse and they were able to tell us what they would do if they had any concerns. One staff member said, "I'd speak to [name of manager] if I saw anything I didn't like." The manager and deputy manager were also aware of their responsibilities in regard to reporting and investigating concerns or incidents. Staff we spoke with were aware of the whistleblowing procedure and how to use this. We saw information regarding whistleblowing was on display within the home and when we asked a member of staff about whistleblowing, they told us "It is when a worker reports suspected wrong doing at work". A whistle blower is someone directly employed by the registered provider who reports concerns where there is harm, or the risk of harm, to people.

Two people who lived at The Oakes told us about a person who sometimes came into their bedroom. We reviewed the care records for the person who they had told us about and we saw there had been incidents where they had gone into other people bedrooms and disturbed them. We spoke with the deputy manager on the day of the inspection and the manager following the inspection and we were re-assured that actions were being taken to address the situation and reach a satisfactory outcome for people who lived at the home.

We saw risks to people had been identified, assessed and reviewed. These covered, for example, falls, choking, accessing baths, use of locked doors, dehydration and malnutrition. One person had a risk assessment for a specific health condition which they had previously suffered from. The risk assessment indicated the signs staff should look for and action they should take in response. This showed risk assessments considered people's medical history and their care needs.

The risk assessment for one person's pressure care stated when they were seated; their pressure cushion should be in place at all times. We found three occasions during day one of our inspection when this person was sitting in different areas of the home and on each occasion the person was not seated on their pressure cushion. We brought this to the attention of the senior care staff on duty, we also spoke with a visiting health care professional; they told us they had no current concerns about this person's skin integrity.

Where people were identified as being at risk of falls we saw there were strategies in place to either reduce the risk of falls or reduce the risk of injury in the event of a fall. For example, bed rails, low beds, crash mats and floor sensors. One person told us they had a mat at the side of their bed, they told us if they got out of

bed in the night the buzzer sounds and staff came to check they were safe.

Care plans contained a number of documents related to moving and handling. The records for one person were very basic and lacked the relevant detail to reduce the risk of harm to either the person or staff. For example, the document noted they needed two staff to support them to change position in bed but no reference was made to the use of a slide sheet which staff told us they used. There were also two pieces of equipment listed but no instruction as to which should be used and under what circumstances. We brought this to the attention of the manager and when we visited the home for the second day of the inspection they told us of the 55 people who were living at the home, 50 people's moving and handling documentation had been reviewed and re-written to improve the quality of the content. They showed us the updated moving and handling information for the person whose records we had previously reviewed and we saw a number of improvements had been made to the level of detail including risk assessments for the specific equipment they used.

Accident and incidents were recorded. There was a system in place to analyse and review accidents and incidents, these enabled changes to be made to their care and support to reduce the risk of future falls or injury from falls.

The registered provider had a system in place to ensure people's safety was maintained.

We saw evidence external contractors were used to service and maintain equipment, for example, gas appliances. We also saw moving and handling equipment had been serviced in line with the Lifting Operations and Lifting Equipment Regulations 1998 (LOLER). Records evidenced regular internal checks were completed on the emergency lighting checks, passenger lift, hoists and slings. Earlier in 2017 we had been notified by the registered provider of an incident which had resulted in harm to a person who lived at the home; this had been caused, in part by faulty equipment. We spoke to the maintenance person and they showed us the changes that had been implemented following this incident to reduce the risk of this re-occurring.

At our last inspection we found fire extinguishers had been locked away on the first floor as one person had tried to pick them up. At this inspection, we saw fire extinguishers were in place across both floors. These were kept in protective cases which staff would be able to easily access in an emergency. Fire escapes were unobstructed and fire-fighting equipment was available. The fire alarm system was regularly maintained and tested on a weekly basis and the home displayed the emergency evacuation procedure plan and fire drill procedures in prominent places. We looked at four care plans and saw personal emergency evacuation plans (PEEPs) were in place. This is a document which details the safety plan, e.g. route, equipment, staff support, for a named individual in the event the premises have to be evacuated.

Safe recruitment practices were in place. We looked at five staff recruitment files and saw application forms had been completed; references and Disclosure and Barring Service (DBS) checks had been obtained. DBS checks return information from the Police National Database about any convictions, cautions, warnings or reprimands and help employers make safer recruitment decisions and help to prevent unsuitable people from working with vulnerable groups. We noted one staff members DBS was dated April 2012. Although it is not mandatory that these checks are renewed, ongoing monitoring of staff DBS checks helps to ensure staff remain suitable to work with vulnerable people.

We asked people if there were enough staff on duty to meet their needs. One person told us if they pressed their nurse call "They are there in no time." Another person told us staff responded quickly if they needed them. However, one person told us they would like more baths but said staff had told them they were 'too

busy'. We brought this to the attention of the manager after the inspection.

Staff told us they were busy and felt an addition member of staff would be beneficial, one staff member said, "I think they can do with some more staff. They could do with a couple more upstairs." However, during the period of the inspection, although we saw staff were busy, people's needs were met in a timely manner and staff did not appear unduly pressured by their work load and duties. Staff also told us that some staff worked on a particular floor while other staff may be allocated to work on either floor. Staff told us they were happy with this as it ensured people received care from staff that knew them well.

At the last inspection staff who were trained in medicine administration were not on duty every night, this meant people may not have had access to their medicines if they needed them during the night. The manager told us there was a senior care assistant on duty each night and their aim was to have a senior care assistant on both floors. They told us that following a review of the accident statistics, the staffing had also been reviewed and a sixth member of staff had been put on the duty rota at night. However, they explained this had since been reviewed and the shift times had been amended to 6pm to midnight and 6am until noon. They said this had enabled them to increase the staffing at the home during peak periods of activity; however, these shifts were not yet fully operational as further staff recruitment was needed to cover these extra hours. This showed the manager was designing the staffing around the needs of the people who lived at the home.

Some medicines were supplied in a monitored dosage system (MDS).This meant the medicines for each person for each time of day had been dispensed by the pharmacist into individual trays in separate compartments, while others were supplied in boxes or bottles. For recording the administration of medicines, medicine administration records (MARs) were used. The MARs showed staff were signing for the medication they were giving. The MAR contained a photographic record for each person; any allergy information and personal preferences were noted of how they wished to take their medicine. For example, 'prefers with orange juice'. During the administration of medicines, we saw these preferences were followed. MARs we looked at showed there were no gaps in recording which meant people consistently received their medicines.

Medicines were stored in a locked room which could only be accessed by authorised staff. Fridge and room temperatures were monitored on a daily basis and these records showed medicines were stored appropriately. Protocols for the use of medicines prescribed for use 'as and when required' were in place and contained sufficient information for staff to know when it was appropriate to offer these medicines.

Controlled drugs are medicines that have additional requirements around storage and recording. We saw controlled drugs were securely stored and on day one of our inspection, the person responsible for administering medicines found another member of staff to counter-sign for the use of a controlled drug. The two members of staff routinely checked the stock held matched the outstanding amount recorded in the controlled drugs register. However, we saw the recording of one person's pain patch required improvement. The instructions noted the patch was to be applied every three days. The patch application record used to indicate when and where patches were used stated a patch had been applied on 6 July 2017 and removed on 12 July 2017. We checked the controlled drugs register which showed a new patch had been applied on 9 July 2017, although the gap in recording meant staff could not be certain they had applied the patch to a different area of the person's body, which is recommended.

We looked at the management of medicines which were required to be administered before breakfast and found this was not safely managed on the first floor. Three people prescribed Lansoprazole received this just after their breakfast. The instruction on the MAR showed this should have been administered 30 to 60

minutes before food. We were told by a member of staff that an early medicine round did not take place. However, this arrangement was different on the ground floor as a senior carer was present to ensure people received early morning medicines as prescribed. We raised this with the manager and they told us they would review this promptly. We spoke with the manager after the inspection and we were satisfied they had taken action to address this matter.

We looked at the recording of topical creams and lotions on the first floor and found this was not adequately recorded. One person was prescribed derma cream 'apply up to three times daily'. We saw a total of three occasions in June 2017 and a further three occasions in July 2017 when this was recorded as applied. Another person was prescribed zerobase cream as 'apply up to four times a day'. There was evidence of two occasions in June 2017 and three occasions in July 2017 when this had been applied. This meant we could not clearly evidence creams were being administered in line with the prescriber's instructions. We discussed this with the manager who told us had identified this concern and had already spoken with staff about the importance of recording all applications of topical creams and lotions.

We recommend that the service consider current guidance on the management of time specific medicines and topical creams and lotions.

We spoke with one member of staff whose responsibilities included administering people's medicines. They told us they had completed an e-learning course regarding medicines management and an assessment of staff's competency was completed before staff were able to administer medicines without supervision. We saw evidence of this in one of the staff files we reviewed. This meant people received their medicines from staff who had the appropriate knowledge and skills.

Requires Improvement

Is the service effective?

Our findings

People felt staff had the skills to enable them to do their job. One person said, "I am sure the staff know what they are doing, I am happy with them, I am happy with my care and support." Although another person commented, "They are not all competent, same of the newcomers, you can tell them things every day and they still forget." A relative said, "Yes I am sure they are competent." Another relative said, "If [person] is unwell, they ring me straight away."

A visiting health professional told us the service worked well in responding quickly to changes in people's healthcare needs. Referrals from staff were said to be appropriate and timely. The health professional told us, "Since the manager changed, it's got better. He gets equipment in quickly."

Staff told us new staff completed a programme of induction which included formal training and shadowing a more experience member of staff. The induction process was completed over a twelve week time frame and included the requirements of the Care Certificate. This is an identified set of standards that health and social care workers adhere to in their daily working life. It aims to ensure that all workers have the same introductory skills, knowledge and behaviours to provide compassionate, safe and high quality care and support.

Each of the staff we spoke with told us they received management supervision. Staff also told us they felt they could speak openly in their supervision. One staff member said, "You can tell them stuff, it does actually get done now that [name of manager] is here." However, one staff member told they had not had supervision for over a year. We raised this with the manager and they showed us evidence this member of staff had received supervision. We saw staff supervision was recorded on the registered provider's electronic monitoring system; this enabled the manager to have oversight of all staff to ensure each member of staff was receiving regular supervision and appraisal.

Staff told us they received regular training which was a mixture of face to face and e-learning. One staff told us they had individual online accounts to access their training and they received notifications when specific training was due to be refreshed. The manager had oversight of staff's training compliance and we saw a matrix clearly identified when staff had completed courses, when they were due to refresh and if they had not completed their training within the required time frame. We saw overall training compliance was monitored through the area director's audits of the home. A report dated 15 June 2017 recorded staff learning and development compliance was 78%, the registered providers target for compliance was 85%. The manager told us action was ongoing to ensure all staff had completed and refreshed all training which was relevant to their role. Ensuring staff receive thorough training and regular updates helps to ensure staff have up to date knowledge to enable them to meet people's needs in line with current standards of good practice.

The manager told us they wanted to ensure staff had the necessary skills to enable them to do their job well. They explained three staff were currently completing a train the trainer course in moving and handling. They said this would enable them to teach other staff, ensure staff adhered to good practice course as well as

working with other staff to ensure people's moving and handling documentation was fit for purpose. This showed the manager was working towards achieving high standards of care by creating an environment where clinical excellence could do well.

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.

We found the records relating to capacity assessments and best interests decision making were not consistent. For example, one of the files we reviewed evidenced deterioration in the person's cognitive skills. We saw evidence of a capacity assessment and best interest's decision making regarding the use of bed safety rails. Another care plan contained a variety of capacity assessments including falls, medication and personal care. However, we reviewed the care plans for two people who lacked capacity to manage their medicines but no capacity assessment had been completed for this aspect of their care. In another care plan a member of staff had recorded on some of the risk assessment forms 'written in best interests'; but there was no evidence of best interests decision making for these and no evidence of the involvement of others in the decision making process, for example family members. Following this process demonstrates openness and transparency in providing services for people who lack capacity as prescribed in the Mental Capacity Act 2005.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals 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 manager told us twelve people who lived at the home were subject to a DoLS authorisation, only one had a condition attached. We spoke with the manager about this and they told us how this was being managed. We also saw evidence a further sixteen had been applied for and were awaiting review by the local authority.

Staff we spoke with were clear about people's right to make their own choices and decisions. Staff told us how they supported people to make choices and during our inspection we heard staff asking for people's consent, for example, before administering medicines, serving meals or supporting with moving and handling.

At our last inspection we saw meals were taken to people's bedrooms uncovered and people were not always offered choices regarding their meals and drinks. On this inspection we found improvements had been made.

People gave positive feedback about the meals at the Oakes. One person told us about a specific food allergy they had but they told us they were always provided with a suitable alternative. Another person told us, "The meals looked good and are well presented." A relative commented. "There is a good variety and choice of food and it is well presented, they don't over face [name of person] as they are a light eater."

There was a restaurant room situated on each floor. Both were well presented with table cloths, crockery, cutlery and condiments. Jugs of juice were on each table and there were snacks and fruit available for people to help themselves.

We observed meal times on both floors. At breakfast time people came in to the restaurant over a period of time. Staff encouraged people to decide where they wanted to sit and we saw people were offered a range of options including cooked breakfasts, porridge, cereals and toast. At lunchtime the meal looked appetising and of sufficient quantity. Although staff plated people's meals from the hot trolley we heard staff discuss choices of meal and portion sizes with people and between themselves. People were served in a timely manner and there was friendly banter between staff and people who lived at the home. Where people ate meals in their rooms; meals were taken on trays with a cover over the meal to retain the heat and prevent contamination. People were offered a choice of cold drinks with their meal and hot drinks were offered shortly after the main course had been served. People looked to be enjoying their meal and we heard one person say, "I enjoyed that."

The manager told us they had been speaking with staff and people who lived at the home about changing meal times at the home, for example, moving the main meal of the day to evening time. They also told us that following the fitting of the breakfast bar in the ground floor restaurant they planned to have one fitted in the first floor restaurant room. The manager said that since they had commenced work at The Oakes a lot of work had been undertaken by themselves and staff to increase the volume of fluid people consumed throughout the day. They said as a result of improving people's hydration the number of falls and urinary tract infections had reduced. During our inspection we saw staff providing people with drinks throughout the day and both encouraging and supporting people to drink. Jugs of juice were available at meal times and drinks were offered in-between meals. The manager said jellies were routinely offered to people mid-morning and they said this also improved people's fluid intake. We saw people being offered jelly on both days of our inspection.

People's care plans contained assessments pertaining to people's nutritional risk and risk of choking; people were weighed at regular intervals. We saw a monthly analysis was completed of people's weights and nutritional risk. This assisted staff in identifying where people were losing or gaining weight and enabled staff to seek medical advice and implement appropriate action to redress the matter.

People told us they had access to GPs', opticians and chiropodists. We saw evidence in people's care plans of the involvement of external healthcare professionals including, GP's, district nurses and community dieticians and mental health teams. We saw one person's care plan for skin integrity noted staff had found some redness relating to pressure areas. On the same day this was identified, the care plan evaluation showed barrier cream had been requested from the GP. This showed people received additional support when required for meeting their care and treatment needs.

The Oakes has two distinct units over two floors. Both units were homely, nicely furnished and decorated. Each floor had a variety of seating areas for people to spend their time. People's bedrooms were identified by way of the person's name and bedroom number. On the floor which provided care for people living with dementia, we saw older items of interest designed to help people reminisce. For example, there was an old typewriter, a house telephone and a cash register used in shops. Outside the premises, there was an old fashioned telephone box. Reminiscence boxes were outside each person's room to help them recognise their own living space; these included small items of interest, such as family photographs. We saw these were sometimes positioned part way between rooms, rather than directly outside specific doors, which may have confused people about the exact location of the room they lived in.

People's bedroom were clean, tidy and odour free. We noted people's bedrooms contained photographs, pictures and personal mementoes. Personalising bedrooms helps to create a sense of familiarity and make a person feel more comfortable.

Good

Is the service caring?

Our findings

Our inspection on 11 April 2016 found the registered person was not meeting the regulations in regard to ensuring people were always treated with dignity and respect. At this inspection we found a number of improvements had been made.

Everyone we spoke with told us staff were kind and caring. People's comments included; "They are nice and conscientious, I am nice to them and they are nice to me," "The staff are nice to me I have a special one, [name of staff], they are wonderful, I wish they were all like that", "They're all nice here" and "I like being here." A staff member said the service provided good care, they told us, "Without a shadow of a doubt, a lot of people are very compassionate. It's really nice here." Another staff member said, "I am quite passionate about it, I want people to be treated well, they deserve to be treated well." A health professional told us, "We always find people clean when we go to them, especially bed bound and palliative."

Throughout the inspection we observed and heard kind, friendly and appropriate interactions between all levels of staff employed at the home and the people who lived there. Staff spoke with people as they passed them on corridors and as they entered communal areas. When we spoke with staff they clearly knew people well. People looked well cared for; they were tidy and clean in their appearance which was achieved through good standards of care. People were dressed appropriately and staff ensured people were wearing appropriate footwear. Music playing was relevant to the era people grew up in. We saw people and staff in the lounge on the first floor, having a sing-song and observed people taking genuine pleasure in joining in.

On the first day of our inspection, we saw staff were attentive and showed empathy to one person who was particularly tearful. They provided comfort and reassurance to this person and tried to find appropriate ways to divert their attention. We saw staff identified and responded to people when they became agitated and took time to talk to them. We also saw the manager spend time with a person who was becoming anxious; they talked to them about their previous employment and the people they knew.

Staff we spoke with understood the importance of maintaining people's privacy and dignity and gave examples of how they would implement this. Examples staff gave us included, closing doors and curtains and knocking on doors before entering. We observed staff put this into practice as part of their daily routine, for example, we saw a member of staff walk along the corridor, they saw a person had gone into a bathroom and not closed the door behind them. The member of staff stopped what they were doing, turned the light on for them, checked they were ok and closed the door to ensure privacy.

The cook told us there was no-one currently living at the home who required specific food or meals to meet their cultural or religious needs. We saw as part of the care planning process dietary needs were recorded in people's care records and considered options such as halal, kosher and vegetarian. This meant people's cultural needs were assessed and considered to ensure their individual needs and preferences where maintained.

People's care plans recorded the skills and tasks they were able to complete themselves. For example, one

person's personal care plan read 'likes to be independent but needs a reminder to use the shower.' Another care plan recorded, '[Person] will clean their own teeth if you put a bowl and towel on their lap'. Encouraging people to retain life skills can be a key part of living well in older age.

Five of the people we spoke with told us they knew they had a care plan but they said they had not seen it. The manager told us the registered provider operated a 'resident of the day'. They explained that part of this process was a monthly review of individuals' care plans alongside either the person and/or their family. One of the relatives we spoke with told us they had recently had a phone call from a member of staff, they had asked them about their mum's care plan and care needs. They also said the manager had since spoken to them to update them on the topics they had discussed on the telephone. We saw evidence the manager had begun to embed this process; this included a resident of the day planner and evidence of invites to family members to be part of this process. This showed the manager was supporting people to become actively involved in making decisions about their care, treatment and support.

Requires Improvement

Is the service responsive?

Our findings

We asked people about the activity programme at The Oakes. One person said, "A nice young man from University comes and plays the piano, the activities lady runs quizzes and it is our own fault if we don't join in." Another person told us, "On the dementia ward they had a shop where you can buy drinks and sweets, it is open on Monday and it is a really lovely shop, old fashioned with the things we used to have." We spoke with another person who told us they had spent time sorting out mismatched socks with the wellbeing co-ordinator. They told us they had enjoyed doing this. A relative told us, "They have singers, comedians, large card games, some pupils from the music school come and sing, they have music for the brain, afternoon films, a beach in the cellar and they take them on trips such as on a canal boat."

However, one person told us they would like more social events. Another person said they would like more 'brain stimulation'. One person told us they used to love gardening. The manager said there were plans to improve part of the garden and this person would be involved in this if they wished. When we reviewed feedback from a quality survey completed in June 2017 we saw people had also commented that they would like more activities to be provided. We saw minutes from a resident meeting dated 20 July 2017 that the manager had discussed the activity programme with people and what they were looking at implementing to address these issues.

The manager told us the home employed a well-being co-ordinator, there role was to plan, organise and implement a social programme for people. We saw information about the weekly activity programme was on display within the home. We spoke briefly with the well-being co-ordinator, they told us when someone new was admitted to the home they met with them and their family if needed, to find out what they enjoyed doing. They said where people were not able or did not wish to participate in group activity sessions; they would ensure they received dedicated one-to-one time with them.

During the time we spent at the home we saw people watching films and listening to music. In the afternoon on the first floor we saw a member of care staff actively engaging with a small group of people playing dominoes. The staff member was a key factor in the success of the game with their verbal encouragement, laughter and enthusiasm.

The deputy manager told us an assessment of needs was completed prior to anyone moving into the home. This is an initial assessment used to determine people's care and support needs as well as how the service proposes to meet those needs. The deputy manager explained a new person would only be admitted to the home if they were confident their needs could be met.

Not all the records we looked at were complete. For example, the cover of care plans contained some personalised information about people, such as the name they wanted to be known by, whether they preferred a male or female carer and important things about their life. One person's notes about their important things stated 'My family. My jewellery. I like to look nice. During the day I enjoy singing and watching films, especially musicals.' However, in five of the care plans we reviewed life history documentation had not been completed. This is a tool that can be used to record people's history, interests,

likes and dislikes. It can help staff to engage people in meaningful conversations and encourage social interaction and communication.

The level of detail and information in people's care records was inconsistent. For example, care plans for night routines were well written as they contained lots of details about how people prepared for bed time. Another care plan provided clear details about a particular aspect of one person's care needs. However, other care plans lacked details which would ensure staff could provide person centred care. For example, an activity care plan for one person dated 26 May 2016 recorded 'can be sociable but also likes to spend time alone' and in the section 'previous hobbies and activities enjoyed' staff had recorded 'going in garden, watching TV, chatting to others'. There was no information as to what they enjoyed watching on TV, what they enjoyed chatting about or to whom. We spoke with the manager regarding this, they told us they were aware of the shortfall in information in some care plans and they assured us action would be taken. When we returned for the second day of the inspection the manager showed us an example of a care plan that had been reviewed following our visit. We saw this contained relevant information which would enable staff to provide effective, person centred care to that person.

The manager told us they had combined a number of different daily recording documents, including eating and drinking, personal care and re-positioning charts, onto one document. They explained this was to reduce the number of forms staff had to complete. We reviewed a random sample of records. There were two forms for two people which recorded their daily personal care, none of the forms were dated and they were both on the old style of paperwork. We also reviewed the records for a third person, whose records were in the new format. We saw staff had recorded their personal care and on some days they had recorded what they had eaten and had to drink. We asked a member of staff if this person needed their food and fluid recording they told us they did not. We spoke with the manager and they told us they would ensure information was available to staff to ensure they knew which sections of the document staff were to complete for each person.

There was a complaints procedure in place. We saw that recent complaints were acknowledged and responded to in a timely manner. We reviewed a complaint which had been received by the manager during May 2017. We saw details of the complainant, the issues raised and the action taken to address the issues were all recorded. This showed there was a system in place to respond to, and monitor concerns raised about the service.

We reviewed a random sample of compliments which had been had been received, comments included; 'The new management is excellent in every way. The staff are much happier in their jobs and this they have told me', 'I admire the way the staff relate to my mother, treating her with respect and care' and 'very good to live here.'

Requires Improvement

Is the service well-led?

Our findings

Our inspection on 11 April 2016 found the registered person was not meeting the regulations in regards to good governance. At this inspection we found a number of improvements had been made.

The registered provider is required to have a registered manager as a condition of their registration. There was a manager in post on the day of our inspection, they had commenced their application to be registered with the Care Quality Commission but the registration process was not yet completed.

People spoke positively about the new manager and the impact they were having on the home. One person said they knew who the manager was and they spoke with them on a regular basis, "He always seems to be available." When we asked people about what was good about the home, comments included; "It's good, the cheerfulness of the people like [name of manager], I hope they all feel as I do, that they are as reasonably happy as I am", "It is comfortable, I feel at home, my bedroom is lovely with my own things around me" and "My room is nice, the food and entertainment are good and I can't think of anything I don't like."

Staff were also positive about the current management of the home. One member of staff said, "[Manager] is really good. He's got a good personality. He fills you with confidence. I can say anything to him, he's very approachable." Throughout the inspection we saw the manager had a visible presence throughout the home and demonstrated they knew people by name and showed an understanding of their needs. They spoke to us with enthusiasm about their role and their plans for the home.

There was a system in place to monitor the quality of the service people received, although this had not identified the issues and rectified the issues we identified as part of our inspection process.

A number of internal audits were completed. For example; a twice daily walk around was completed by the manager or another senior staff member, infection prevention and control audit was done twice yearly and a number of care plans were audited each month. The care plan audits recorded where action was required and when the action had been completed. Audits of medicines were also completed, including a random daily stock audit and a more in-depth monthly audit, although they had failed to identify the issues we raised during the inspection.

Other audits were also completed by managers who were not involved in the day to day running of the home. This included a quality audit which had been competed in February and June 2017 and a health and safety audit, most recently completed in February 2017.

The manager submitted a monthly report to the registered provider. This included information regarding falls, pressure sores, infections and admissions to hospital. The area director told us they reviewed this information when they were planning their monthly audit of the home. This meant they were aware of possible concerns and able to target their support if needed, to areas of particular concern.

We saw evidence a monthly visit report was completed by an area director. The report covered a range of

areas including falls, staffing, complaints and the environment. We saw the report recorded the findings of the area director and included an actions log with a timescale for the completion of each item. However, it was not always evident that identified actions had been completed to the required standard and within the requested timescale. For example, the action plan section of the report dated 6 March 2017 noted 'All staff to complete Dignity training on touch', the report dated 3 April 2017 had no reference to this in the action plan although the section 'pre site preparation' recorded '3 to complete dignity as part of the CQC breach'. This meant we were unable to clearly evidence areas identified as needing attention had been addressed.

Staff told us regular staff meetings were held and we saw the dates of future monthly meetings were on display within the home. Staff felt they could speak openly at the meetings and that action was taken as a result of topics raised. Each day a 'flash meeting' was held. We were invited to attend the meeting on the first day of inspection; present were representatives from all departments within the home. The meeting was short and structured with each person sharing information pertinent to the day to day running of the home, people and staff's well-being. The deputy manager said these meetings were beneficial and aided communication. They said the manager was encouraging staff to hold the meetings every day of the week. Staff meetings are an important part of a manager's responsibility to ensure information is disseminated to staff appropriately and to come to informed views about the service.

There were systems in place to gather the views and opinions of people who lived at the home and their relatives. People who lived at the home were unsure if they had received or completed a feedback survey however, we reviewed 22 completed surveys dated June 2017. Comments included feedback regarding the activity programme at the home. Regular resident and relative meetings were held at the home. A relative said, "[Name of manager] runs regular meetings to see what is going on. If you want to see him he always makes himself available." We saw the dates of future meetings, in September and November 2017 were on display within the home.

Under the Care Quality Commission (Registration) Regulations 2009 registered providers have a duty to submit a statutory notification to the Care Quality Commission (CQC) regarding a range of incidents. At the last inspection we identified incidents which had not been reported to the CQC. Prior to the inspection the manager informed us they had identified a small number of incidents which had not been reported and they submitted these notifications retrospectively.

There is a requirement for the registered provider to display ratings of their most recent inspection. We saw a poster displaying the ratings from the previous inspection was on display; however, this was in the manager's office and therefore not easily viewed by people visiting the home. This was raised with the manager and they promptly re-located the poster. A link to the CQC report was also available on the registered provider's website.

During this inspection we found a number of improvements had been made since our last inspection relating to relating to dignity and respect, staffing and good governance. However, we identified shortfalls regarding the recording of some medicines, risk assessments, care records and meeting the requirements of the Mental Capacity Act. Future inspections will seek to evidence a sustained and consistent high level of quality has been achieved and that systems of governance remain reflective, transparent and robust.