Speciality Care (EMI) Limited

The Oaks

Inspection report

904 Sidcup Road
New Eltham
London
SE9 3PW

Tel: 02088579980
Website: www.craegmoor.co.uk

Date of inspection visit:
13 June 2016
14 June 2016
16 June 2016

Date of publication:
29 July 2016

Ratings

Overall rating for this service	Good

Is the service safe?	Good
Is the service effective?	Requires Improvement
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 13, 14 and 16 June 2016 and was unannounced. At the last inspection in March 2015 we had found a breach of legal requirements in respect of medicines. We also made a recommendation for the provider to consider ways of making the environment more dementia friendly. We carried out this inspection to check that the action plan the provider had submitted at the last inspection had been completed and legal requirements were now met and to provide a fresh rating of the home.

The Oaks is a nursing home which can accommodate up to 113 older people with dementia or mental health needs across six units. At the time of our inspection there were 90 people living at the home. There was a registered manager in place who had started to work as manager at the home just prior to the last inspection in March 2015. 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.

At this inspection we found a breach of regulation where people may lack capacity to make a particular decision; records showed their capacity was not separately assessed for each decision. You can see the action we have asked the provider to take at the back of the full version of this report. People were asked for their consent before they were provided with care or support. Applications for Deprivation of Liberty Safeguards authorisations had been appropriately made in line with current guidance.

We found improvements had been made in relation to medicines which were now safely and consistently managed across the home. Considerable improvements had been made to the environment to make it more suitable for people living with dementia. People and their relatives told us they felt safe at the service. Staff understood signs of abuse or neglect and knew how to report concerns. Individual risks to people were identified and monitored. There were processes in place to manage emergencies. The premises and equipment including emergency equipment were routinely checked, serviced and maintained. Recruitment checks were in place before staff started work to reduce the risk of unsuitable staff being employed. There were enough suitably qualified staff to meet people's needs. We observed that no one was waiting for care and support throughout the day and call bells were answered promptly.

People and their relatives told us staff were kind and helpful. People were not rushed and their privacy and dignity was respected. People's end of life care was sensitively and appropriately managed. Staff received supervision, appraisal and suitable training across a range of areas and told us they felt supported to enable them to carry out their role.

People had plenty to eat and drink and were encouraged to be independent or supported, where needed, at their own pace. The home worked with a wide range of health and social care professionals to meet people's health needs. People's needs were assessed to ensure they could be safely met. Care and support was planned to meet their individualised needs. There was a regular activities programme, which had been

extended to include a wider range of opportunities for stimulation and interaction. Further improvements in the range of activities offered were being introduced.

People, their relatives, staff and health professionals told us the service was well led. The management team looked for ways to constantly improve the service. The views of people at the service, relatives, staff and visiting professionals were sought and used to make improvements. Complaints were responded to in line with the provider's policy. People knew how and where to complain if they had a problem. There were systems in place to monitor the quality of the service and issues identified were acted on.

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.

Medicines were safely stored, administered and managed.

People told us they felt safe. Staff knew how to protect people from abuse or neglect. There were sufficient numbers of staff to meet people's needs and effective recruitment procedures were in place.

Risks to people were assessed and monitored, and guidance was available to staff on how to safely manage these risks. There were arrangements to deal with emergencies.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff asked for consent before they provided care. They understood the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS) and there were procedures in place to support staff to act in accordance with the legislation. However records did not evidence that people's capacity was assessed for each specific decision in line with the MCA

Staff received training and support to meet people's needs. People told us they had enough to eat and drink and there was enough choice.

People had access to health care professionals when they needed and the service worked closely with different professionals to ensure people's health needs were met.

Improvements had been made to the environment to make it more suitable to people living with dementia.

Is the service caring?

Good

The service was caring.

People and their relatives told us staff were kind and caring and

we observed this to be the case. People and their relatives told us they felt safe and well supported.

We observed that staff showed dignity and respect towards people. We saw positive interactions between staff and people using the service and staff knew people well.

People and their relatives told us they were involved in decisions about their care.

Is the service responsive?

Good

The service was responsive.

People had an up to date individualised plan of their care which reflected their current needs. The manager told us they were working to ensure they were consistently personalised.

People's needs for stimulation and social interaction were recognised and provided for.

People and their relatives knew how to make a complaint and complaints were dealt with in line with the complaints procedure.

Is the service well-led?

Good

The service was well- led

People, relatives, staff and health professionals were positive about the manager and clinical lead. The registered manager told us she was well supported.

There was a structure of meetings to manage the home and there were effective systems to monitor risk and review the quality of the service. Issues were addressed and learning and any necessary actions identified and carried out.

People's views were sought about the running of the service through meetings, feedback forms and an annual survey.

The Oaks

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 13, 14 and 16 June 2016 and was unannounced. On the first day the inspection team consisted of two inspectors and a specialist advisor. Two inspectors returned in the evening to observe the care at night. On the second day the inspectors and specialist advisor were joined by 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. On the third day one inspector and a pharmacy inspector returned to complete the inspection.

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. As part of our planning we looked at the information we held about the service including the PIR and information from any notifications the provider had sent us. A notification is information about important events that the provider is required to send us by law. We also asked the local authority commissioners for the service and the safeguarding team for their views of the service.

During the inspection we spoke with thirteen people who used the service and nine relatives. We used the Short Observational Framework for Inspection (SOFI) on each unit at the home. SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We spoke with both day and night staff. These included nine nurses, twelve health care assistants, two administrative staff, two maintenance staff members, the activities coordinator, two members of the activity team, and the chef. We also spoke with the registered manager and clinical lead for the home. We spoke with the GP visiting the service and two visiting health professionals. We also contacted three healthcare professionals after the inspection to gather their views. We looked at fourteen people's care records. We tracked seven people's care to see if the care they received was in line with their care plan. We looked at nine staff recruitment and training records, and records related to the management of the service such as minutes of meetings, records of audits, and service and maintenance records.

Good

Is the service safe?

Our findings

At the last inspection in March 2015 we had identified a breach of regulation as medicines were not always managed safely on one of the six units at the home. At this time the manager had taken immediate action to address the most serious issues with medicines. Following the inspection they sent us an action plan detailing how they would address the remaining issues.

At this inspection, we checked the service's arrangements for the management of people's medicines, by checking a sample of medicines records and medicines supplies for 57 people throughout the home. We found that medicines were now managed safely, and the processes in place were now robust enough so that we were assured that people were receiving their medicines as prescribed.

People told us they received their medicines on time. One person said, "Yes I do, I'm diabetic so I also get my blood sugars tested before I eat every day." Another person commented, "I get given them by the nurse every morning, so I don't have to worry about remembering." Medicines administration records (MAR) were completed clearly, with no gaps observed. There was information about people's allergies and time critical medicines. Medicines that were not in blister-packs were counted daily, to check for accurate administration. This provided assurance that people were receiving their medicines as prescribed. We observed medicines rounds, and saw that people were not rushed when staff administered their medicines to them.

There was regular input from the mental health team for people with mental health issues or dementia, and the community pharmacist had also recently carried out an audit on antipsychotic medicines, to assess whether these were being used appropriately. We saw there was no overuse of sedating medicines. When necessary and appropriate there were suitable arrangements for some people without capacity to consent, to administer their medicines covertly, in line with guidance, to ensure that people continued to receive essential medicines so their health was not put at risk.

For people on medicines for diabetes, care plans were in place for their health needs. There was evidence that people's blood glucose was monitored regularly, at the frequency specified in their care plans. Controlled drugs were managed and stored safely and in line with legal requirements. Protocols were in place for 'as required' medicines. Medicinal creams were administered safely. All medicines were stored securely and at the right temperatures to remain effective. All members of staff with responsibilities for medicines had received medicines administration training and had their medicines competency assessed. The training and competencies were regularly refreshed to ensure staff remained competent and up to date.

People told us they felt safely cared for and protected from the risk of harm. One person told us, "Yes I'm very safe thanks; they make you feel at ease." A second person said, "Of course I do. Put it this way, I don't feel unsafe." Relatives commented they felt their family members were safe at the home. One relative remarked, "People's safety is considered a lot here." Another relative told us, "I think [my family member] is in good hands, without a doubt. I wouldn't have left them here otherwise."

Staff we spoke with said they had received training in safeguarding adults and felt able to raise any concerns should they have any with the manager. One staff member told us, "People are treated well here. I would go to the nurse or the manager if I had any concerns." Another staff member said, "I'd go and see the nurse." Staff felt confident that senior staff would take action appropriatly and said they would go to the Local Authority or CQC if action was not taken. We saw posters displayed in units which encouraged people and staff to 'speak up' and contact the registered manager if they had any concerns about the way people were being treated. The registered manager had raised appropriate alerts and was aware of their responsibilities under safeguarding and worked cooperatively with any investigations. Following a recent safeguarding we saw the recommendations made in respect of one person's care had been implemented.

Risks to people were identified, assessed and monitored to reduce their impact or the likelihood of them occurring where possible. Individual risks to people such as the risk of falls or of choking were identified and guidance for staff was included in people's care plans to help reduce that risk. For example risks to people's skin integrity were reduced through the use of pressure relieving equipment and regular monitoring. Possible risks from falls was monitored and equipment such as pressure mats or movement sensors were in use to advise staff if people were mobile and therefore at risk of falls. For some people there was a one to one staff member with them to help keep them safe and respond if they became distressed. Risk assessments and guidance reflected people's current needs and were regularly reviewed to ensure they remained relevant to people's needs. For people that were unable to use a call bell regular checks were carried out on people in their rooms throughout the day and night.

Risks in relation to emergencies were assessed and planned for. There was a rota of manager cover for any emergency which was displayed for staff awareness. Staff knew what to do in a medical emergency and had received first aid training. Staff told us they had received training on fire safety which we confirmed from records. Fire drills had been conducted for staff to practice how to respond. We found some night staff were not clear about their roles should there need to be an emergency evacuation and the registered manager told us they were in the process of extending the drills to include evacuation practice. A drill with evacuation practice was conducted for night staff following the inspection and we were sent details of this and further planned drills. There was an easily accessible contingency plan with emergency contact numbers and guidance for staff to cover a range of emergencies.

The premises and equipment were checked and regularly maintained to reduce possible risks to people. Checks were carried out on fire safety, pressure relieving equipment and hoists. Checks were made on the premises including window safety, water temperature checks and checks to prevent legionella. We saw where checks had identified a problem, with the emergency lighting this was resolved during the inspection. Gas safety and electrical installation maintenance checks were carried out and the lift and hoists were regularly maintained

We received some mixed comments about the staffing levels. Most people and their relatives told us they thought there were enough staff and they did not have to wait long for staff to respond to them. Our observations overall confirmed this. A new call bell system had been installed at the home and we saw call bells were answered promptly during the inspection. We did not see anyone waiting unduly for staff support or care and there was a constant staff presence in the communal lounge areas. One person told us, "The staff are available when you need them. I'm never short of help." A relative commented, "I think there are enough staff here." Another relative said, "Obviously it would be nice to have some extra hands on deck, but they are coping as it is." However two people told us they felt they had to wait a long time on some occasions for a response to the call bell. One relative told us, "They could do with more staff; they do struggle some days as there are lots of people to look after that need advanced care. If they had more staff they could take residents out into the garden." Another relative remarked that "Especially at weekends it is a

bit limited because some people call in sick at the last minute." Staff told us there were enough of them to carry out their roles on the rota, if they all turned up for duty. We saw the registered manager had a robust system to monitor staff punctuality and attendance. They told us that there could be a delay from when they were notified of an absence until the agency staff could arrive but usually they were able to get replacement staff.

The registered manager told us that staffing levels were frequently reviewed through a dependency tool that assessed the levels of people's needs. Staff levels could be flexible to meet changes in people's needs. Since the last inspection the registered manager had increased the night staffing level on one unit and altered the staffing levels of nurses and care workers on some units to increase the staff on the floor. A floating member of staff was employed to provide additional support at lunchtimes and they could be booked by the units in advance. The registered manager told us the home used a limited number of agency staff to cover current vacancies and tried to use the same small group of agency staff to ensure greater consistency and familiarity for people.

Recruitment checks were carried out before staff started working at the home. This helped protect people from the risk of inappropriate or unsafe care. Staff files and central office records contained details of relevant identity, health, criminal record and character checks which were completed before staff started to work at the service. There was a system in place to confirm checks made on agency staff to ensure their identity and that they had the necessary skills to work at the home.

Requires Improvement

Is the service effective?

Our findings

People told us they were asked for their consent before any care was provided and our observations confirmed this. One person said, "I can do most things myself with a little bit of assistance and I can make my own choices. They do ask me before helping me with things like helping me with my dress." Staff told us about the importance of asking for consent and ensuring that people's wishes were respected. They gave examples of how they did this and one staff member said, "We always ask first." A staff member described how they were able to understand people who may be unable to speak with them; for example how they recognised particular signs which meant they did not want something or were unhappy or distressed.

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 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.

For those people who lacked the capacity to make a decision staff understood the need to check their ability to make each decision separately. We saw evidence that less restrictive options were considered where people lacked the capacity to make informed choices, such as the use of crash mats and movement sensors to alert staff if people got up in the night and were at risk of falls rather than the use of bed rails. Best interests meetings were documented in people's care plans to record those involved in the decisions and the reasons for them. However completed assessments in relation to decision making were not decision specific in line with MCA. For example, one person's assessment stated that they had been assessed as being unable to make informed decisions that affect their life and wellbeing but did not separately assess people's ability to make each specific decision such as for the use of bed rails or sensors for their safety. There was therefore a risk their capacity to make a specific decision would not be recognised.

This was a breach of Regulation11 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

The registered manager took action to address the issues identified and began to ensure that assessments of separate decisions were made and recorded. However, we were unable to verify this was completed at this inspection.

Where people had a DoLs authorisation for their own safety these were monitored to ensure any conditions were met and renewal applications made in a timely way.

At the last inspection in March 2015 we had made a recommendation for the home to find out more about dementia friendly environments, based on current best practice in relation to the specialist needs of the people living at the Oaks.

At this inspection we found considerable work had taken place since our March 2015 inspection to make the home more dementia friendly. People and their relatives told us they thought the environment was better. One person said, "It is better here now and we can get into the garden when we want to." We saw some people enjoyed free access to pleasant conservatory and garden areas. An outside raised garden bed had been planted and further plants and flowers had been grown by people using the service both in and outside of the home. The toilet and bathroom doors had been painted a different colour to make them more obvious to people and aid orientation. Pictures and photographs were displayed on the walls in each unit and staff spoke about the support given by the registered manager in helping them make each unit more homely and comfortable for the people living there. We found there had been considerable improvements to the environment for people living at the Oaks.

One staff member told us, "We have been working hard to make it nicer." People had memory boxes outside of their rooms to help them find their way and these included objects and pictures that were significant to them. For example, their football teams badge or objects linked to their previous employment. A colourful door plaque also displayed their name.

At the last inspection in March 2015 we had found that the meal time experience for people required some improvement. Staff had been unaware of the menu and people were not supported fully to choose their food. Some people had to wait for their meal as they needed staff assistance and support. At this inspection we found improvements had been made.

People told us they were supported to eat and drink suitable foods that met their needs. Most people told us they were happy with the food and choices provided. One person said, "That was very nice and it is usually is." Another person said, "I enjoy the food, there's not much that I don't agree with but I've had it changed when it doesn't suit me." Relatives were also positive about the food provided. One relative said, "I think the quality of food here is good, I've heard of some places where the food is really substandard, but I don't have any concerns about it here. They're good, when I'm here to see mum at lunchtimes the food always looks appetising. Someone always comes round with drinks as well, so that's never a problem."

We observed the mealtime experience across the home. Daily written menus were displayed within dining areas for people to confirm their choices. The registered manager was in the process of completing a pictorial menu for each unit to assist people in making choices. The completed version was sent to us following the inspection. People and their relatives, where appropriate, had been asked to complete a food preferences list to update staff awareness of their likes and dislikes. There was assistive crockery and coloured crockery in use where relevant to help support people's independence with eating. Some staff interactions were brief and task orientated and did not have a positive impact on the individual well-being of people using the service. Others engaged in conversation for a period which the person clearly enjoyed. Our observation of the lunchtime across all units was that care staff provided appropriate support when required to help people eat and drink. We discussed these findings with the registered manager who told us they were working on this and showed us observations were conducted by staff of mealtimes to identify any areas for improvement and to help to continue to make the mealtimes less task orientated and a more social occasion. The audits were discussed with staff with the aim to improve the meal time experience for people.

Staff including kitchen staff knew people's specific dietary needs and preferences for example any cultural

food preferences. Extra staff were available such as activities coordinators to ensure people were supported promptly. Some people were supported by their relatives. The registered manager told us they had introduced a floating staff member for the lunch time period that units could book in advance if needed.

People told us they thought the staff knew how to look after them effectively. One person told us, "I think they get trained well." Another person said, "I'm happy with the way they do things around here." Relatives told us they thought staff were "knowledgeable" about their roles.

Staff new to the home were supported to gain appropriate skills and knowledge to deliver effective care.This included a programme of shadowing experienced staff and training in line with the care certificate; a nationally recognised induction framework for staff new to health and social care. A new staff member told us, "I feel really well supported to learn about the job; the staff are really helpful and friendly too."

Staff completed a programme of training that the provider considered mandatory. This included safeguarding adults, fire safety, manual handling, first aid and dementia awareness training in the form of two separate training programmes. Staff spoke very positively about experiential training they had received from a visiting 'dementia bus' and said it had taught them a lot about what it was like to live with dementia. One staff member described their training as 'fantastic'. The registered manager stated that they had booked this training again for more staff to experience. Another staff member spoke about how they used their training in their work. They had spoken with the person's family to find out about their life and previous occupations, using this information to help make sure the person was able to be meaningfully occupied each day. Records showed that most staff were up to date with their mandatory training and we saw the registered manager and the provider monitored staff training levels closely to ensure training needs were identified and that staff remained up to date with best practice.

Staff told us they received regular supervision and an annual appraisal from their line manager where they could discuss their practice and identify any training needs. They told us they also used staff meetings and group supervision to do this. Records showed all staff had received an annual appraisal and supervision this year but there was some room for improvement to ensure staff received supervision in line with the frequency the provider had decided was necessary. The registered manager had identified where the gaps were and reminders had been sent out to the relevant staff.

People told us they were supported to maintain good health and had access to a range of healthcare professionals when required. These included the GP, dietician, hospital consultants, tissue viability nurse, the chiropodist and dentist. People told us and their records showed they were supported to attend their routine and non-routine health appointments. People's care plans showed staff monitored people's health and wellbeing. Where there were concerns people were referred to appropriate health professionals. Health professional's advice was recorded within care records to remind staff of the care and treatment needed.

Health professionals we spoke with told us that staff were knowledgeable about the people they supported, referred people to them appropriately and followed their advice. One health professional told us, "The nurses are accessible and they have sought advice from myself or other team members whenever needed. I find the nurses to be dedicated to the welfare of the residents that they are looking after and they seem to demonstrate in depth knowledge of the residents in their respective units."

Good

Is the service caring?

Our findings

People told us staff were generally "kind", "friendly" and caring. One person said, "Staff are very good. Above average. If you have something wrong with you they are on top of it." Relatives also confirmed this view. One relative said, "They're lovely it doesn't matter who it is they are all very helpful and responsive." Another relative commented, "They do put the people first, it is very evident, you have probably seen the type of care the residents have been receiving and it's difficult because it's such a big care home but they just get on with it with a smile on their face. I really applaud them for their dedication."

Some people were not able to verbally communicate their views to us. We therefore observed the care and support being provided across the units at the home. We saw that staff were familiar with people using the service and knew how best to support them and how to approach them respectfully in a caring manner. The atmosphere in the communal areas was calm and friendly and we saw staff took their time, did not rush people and gave people encouragement whilst they supported them.

Staff showed good knowledge of people's personalities and behaviour and were able to communicate effectively with them. They demonstrated a good understanding of the needs of the people they supported and could describe people's preferences. There was a keyworker system in place to allow staff to build relationships with people and their relatives and get to know them well. A relative told us, "The staff are approachable, they are nice and try their best, they give good care. They do know [my family member] well now."

An 'All about me' sheet was available in each person's room giving information about them, how they communicated, what was important to them and their strengths to aid new or unfamiliar staff when they provided care and support. People's independence was encouraged. Their care plans provided staff with information about the elements of their care they could manage themselves. One person told us, "No one makes decisions for me, I can make my own." We noted that clocks and calendars on display throughout the home were correct and these were a good aid to support people's orientation.

People and their relatives told us that they had been consulted about their care and support needs and felt involved in the planning and reviewing of their care. Relatives confirmed they were invited to care reviews and decision where relevant. One relative said, "One hundred per cent, they have always kept me in the loop." Another relative explained they had been consulted about a change of room for their family member. Care plans demonstrated that people's preferences were documented and care plans were individualised, reflecting the views and needs of people and their relatives. For example care plans included a section on people's life histories. This documented people's hobbies and interests, place of birth, favourite places, holidays, relationships and former occupations.

People told us they were treated with respect and dignity and our observations confirmed this. One person told us, "They do ask for my permission if they want to help me with anything, I like that, it's very decent." Another person commented, "They don't poke their nose in, they knock." We observed staff discreetly speaking to people about how they wanted to be supported with their personal care. Staff described how

they worked with people to ensure their dignity and privacy was maintained, for example by ensuring doors and curtains were closed when supporting people with personal care. Staff respected people's choice for privacy as some people preferred to remain in their own rooms or not to participate in planned activities.

Staff were knowledgeable about people's needs with regards to their disability, race, religion, sexual orientation and gender and supported people appropriately to meet their identified needs and wishes for example in respect of their clothing preferences and equipment for those unable to mobilise safely. We found people's cultural needs in respect of their diet or needs around personal care had been discussed with people and or their relatives and were recorded and people's spiritual needs addressed through visits from spiritual representatives for those who expressed an interest.

People's end of life care needs and wishes were documented and contained within their care plans to ensure people's wishes and choices were respected. Care plans demonstrated the home worked well with health care professionals to ensure that people's preferences at the end of their life were accounted for. There was evidence of input from the palliative care team. Anticipatory medicines were available for the treatment of pain and other symptoms for two people who were nearing end-of-life, to avoid delays in starting treatment. A syringe driver to aid the administration of pain relief had been ordered and training for nurses was in progress. A health professional commented some nurses, "Have been brilliant in proactively putting in place necessary measures to ensure that residents end of life care is comfortable and dignified."

Good

Is the service responsive?

Our findings

People and their relatives told us there was a written plan for their care and support and that they received care in line with their needs. One person told us, "They do know me and how I like things to be done." People's needs were assessed before they came to live at the Oaks to ensure that the service could meet their identified needs. We found a detailed assessment document to help staff identify people's known needs; however, the provider's dementia care pathway assessment of people's dementia needs had not always been fully completed to help build a more complete picture of people's needs for staff. We discussed this with the manager and clinical lead and during the inspection they revised this section of the assessment document and showed us evidence of its subsequent use as part of preadmisson assessments.

All the care plans we looked at were up to date and evaluated monthly to ensure any changes were recorded and that people had an accurate plan for their care. The plans included care, health and support needs assessments, risk assessments and input from people, health professionals and relatives. Staff completed daily notes to record the care and support that had been provided and the activities the person had undertaken that day. People and their relatives confirmed they were involved and consulted about any changes. People's individual needs and preferences were considered for example one person had brought their pet to the service.

Staff told us how they managed to respond to people's mood changes or behaviour that required a response. For one person we found these were not detailed in their care plan to help guide staff on successful responses. Another care plan stated that the person was unable to participate in activities, and focused on what the person could not do rather than their strengths. We discussed these issues with the registered manager and clinical lead who amended the care plans during the inspection. They told us they had identified staff needed support with recording and were in the process of auditing the care plans and working with staff to ensure that people's care records were consistently detailed, personalised and highlighted people's strengths.

We received some mixed feedback in relation to the provision of activities to meet people's needs for stimulation and social interaction. Most people and their relatives told us there was enough to do and that there had been considerable improvements to the range of activities at the home. One person said, "I love it; visitors get to come anytime, the staff get everyone involved in activities, even the family and friends if they are here, I would give it an eight out of ten." Another person told us, "I like football, it's good for you. I like gardening too and we do that here." A relative told us, "I am helping them grow mint and lavender in their rooms with the [activity coordinator]. She is very good, always finding ways to stimulate them. " Another relative remarked; " The activity coordinator is so friendly and creative and really interacts well with the residents, she knows each of them individually which is the main thing. What more can you ask for? It puts my mind at ease knowing [my family member] is in a safe environment."

However one person and a relative told us they felt there should be more to do and they felt that staff should be available to interact with people more. We noticed a comment on a recent feedback form that asked for more activities. We discussed this with the registered manager and clinical lead and they told us they were

working to ensure that all staff understood the importance of providing social interaction. We saw evidence of this from staff surveys and staff meeting minutes.

We observed the activities on offer had a positive impact on the well-being of people there. There was a wide range of planned activities on display around the home, so that people were aware they were happening. These included arts and crafts, sensory stimulation, physical activity, cooking, gardening and a trip out. Staff ensured people from other units could benefit from attending an activity on another unit where this was appropriate. Activities were also provided for those people nursed in their rooms. There was a leaflet available in the home to explain the ethos around the activities programme and the importance of activities, stimulation and social interaction. An exercise programme had been established with input from health professionals to provided some physical activity with the aim of reducing the risk of falls for some people.

The activities coordinator had clear goals for the activities team and a vision of how they wanted the activities to develop. Life story work had been developed to help establish the needs and individual preferences of people. One person had been given some CD's of their favourite music and another person who had an interest in golf was supported to visit a local golf club once a month. A daily newsletter was made available to people with news items and puzzles to engage people. The home was preparing for an Open Day and we saw an Olympics programme was being offered with a range of physical activities on offer.

People's involvement in the home was encouraged through active roles. Since the last inspection the home had opened a beauty salon and people at the home and been involved with the decorating which we learned had developed their confidence and self-esteem. The registered manager told us the new café/bar which they had almost completed would be run by one of the people at the service with staff support. An ice cream parlour and new sensory room were also being established and there were plans for a radio station to be set up.

People and their relatives told us they knew how to make a complaint. One person said, "if I was unhappy I would complain to the manager." The complaints policy was displayed in the reception area as well as a comments and suggestions box and a visit feedback form for visitors to comment on. A relative said, "I can't say I have had anything to complain about, I've always been happy with the care." Another relative told us, "No I don't have any concerns, but I'm sure if I did they would be very responsive." The complaints policy and procedure was displayed in the reception area to ensure people had access to it. Complaints were logged and responded to in line with the complaints policy.

Good

Is the service well-led?

Our findings

At the last inspection in March 2015 we had found some improvement was needed to the quality monitoring at the home to ensure issues were identified and changes made. At this inspection people and their relatives told us there had been improvements at the home and we found there was now an effective system to monitor the quality of the service.

Regular audits were completed by the manager and the provider across all aspects of the home and the care provided. Areas for improvement were identified and action plans were drawn up and tracked to ensure completion. For example the need for walk-on scales had been identified and these had been obtained. Clinical care and accidents and incidents were monitored and audited and any action required or learning was identified such as a need for increased night spot checks had been identified and we saw these were being carried out. Any issues identified from night visits were discussed with staff in meetings or individually in supervision or could be dealt with through the provider's disciplinary process.

The provider had processes in place to monitor how well medicines were managed through daily and monthly medicines audits. We looked at the completed audits for the last three months and saw that these were effective in identifying issues with medicines, with an action plan drawn up after each audit, and a date of completion for the audit findings, so we were assured that issues were being addressed promptly.

There was a registered manager in place who understood her role and responsibilities as registered manager. People told us they knew who the registered manager was and we saw some people recognised her when she visited the units. One person told us, "She is very nice", another person said, "She comes around and asks if you are ok. I feel able to talk to her and she listens to me." Relatives told us there had been improvements at the service since the registered manager had been in post. One relative told us, "There have been changes, things are better, I have met the new manager, she is very approachable." Another relative commented, "It's very well managed, the whole place has been re-decorated, the lounge, hallways and corridors have been painted, his room has also been re-decorated and has new furniture." A third relative said, "They are improving now, in the middle we were worried and didn't know what was going to happen, but now it has settled."

Staff spoke positively about the registered manager and felt she encouraged them to be actively involved in improving the service and their own development. Comments included, "Fantastic", "supportive" and "puts people first." Staff felt their ideas were listened to and that the registered manager was swift to take appropriate action when needed. One staff member said, "She is very supportive and works very hard; her door is always open and she really encourages you to give your best."

There was a structure to ensure good communication throughout the home and staff confirmed daily handovers took place so they were kept up to date with any changes to people's care and welfare. Handover sheets were used to capture the current information about each person. There were heads of department meetings, nurses' clinical meetings and senior carers meetings to discuss the various roles and responsibilities and ensure communication about people's care was effective. The registered manager told

us she felt very well supported by visits from the provider's representatives. Requests she had made such as for extra staff or new equipment were acted on.

Feedback to improve the home was sought from people, their relatives, professionals and staff through the use of surveys and feedback forms. There was a comments box and a visit feedback form in the reception area. The comments and feedback were considered by the registered manager. One comment stated, "As you walk into the home you have a sense of it being a good home. All the staff are friendly and have the upmost patience."

Relatives and Residents meetings were also held to discuss issues, for example, we saw the use of CCTV for additional security to monitor the outside of the home had been discussed and was being considered by the provider at the time of the inspection. Staff had completed surveys asking their views about activities and their importance and the manager told us she was trying to encourage staff to see them as everyone's responsibility.

Health professionals we contacted commented positively on the leadership at the home. One professional said, "The Oaks nursing team including the manager are pleasant to work with and from my own experience they are always ready to learn or seek advice regarding any clinical matters." Another health professional commented, "If I had to identify a care home that had improved the most in the last year, it would have to be the Oaks and this has predominantly down to the hard work of [the registered manager]. She has really been great and has attempted to do everything I have advised her to do."

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent Arrangements were not always in place to comply with the Mental Capacity Act 2005 Regulation 11 (3).