Oaklands Rest Home Limited

Oaklands Rest Home Limited

Inspection report

Shaw Road
Royton
Oldham
Lancashire
OL2 6DA

Tel: 01616271142

Date of inspection visit:
07 December 2017
08 December 2017

Date of publication:
26 February 2018

Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

We inspected Oaklands Rest Home on 7 and 8 December 2017. Our visit on 7 December was unannounced.

We last completed a full inspection of Oaklands in December 2016, when we found five breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: regulation 9 (person centred care), regulation 15 (premises and equipment), regulation 12 (safe care and treatment) and Regulation 17 (good governance) There was a further breach of the Care Quality Commission (Registration) Regulations 2009 as the service did not display the latest rating. We returned to conduct a focussed inspection in March 2017, when we found some improvements but the service remained in breach of regulations relating to the maintenance of premises and equipment, and good governance. At this inspection we found the service continues to improve, but we made one recommendation that the service responds quickly to external inspections and reviews to improve the safety of people who use the service.

Oaklands is registered to provide accommodation for up to 32 older people who require residential care. At the time of our inspection there were 18 people living at the home. When we visited the home there was a registered manager in place. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements of the Health and Social Care Act 2008 and associated Regulations about how the service is run.

When we toured the building we saw that the home was clean and free from any unpleasant odours. The registered manager showed us where improvements had been made since our last inspection, such as a new medicines room, so that medicines could be stored safely and efficiently; refitted bathrooms and new carpets throughout the building.

The building was secure and staff ensured the safety and well-being of the people who lived at Oaklands; they were aware of the safeguarding and whistleblowing procedures, understood signs of abuse and demonstrated an understanding of how to protect vulnerable people from harm. When we asked, people who used the service told us they felt safe. When accidents and incidents occurred we saw that there was appropriate follow up and investigation to minimise the risk of repeat occurrences. The manager kept a register which showed when any maintenance and safety checks were due.

People were treated with respect, and consideration of their cultural needs and background was taken into account when planning care, along with people's ability to gauge their own risks. When we looked at care records we saw they reflected people's needs and choices. Care plans were detailed and staff kept good daily notes which cross referenced and reflected plans of care. We saw that support was delivered in a timely manner.

There were enough staff on duty, and we saw that safe recruitment procedures were followed. A training timetable showed when staff had attended training courses and reflected good access to training from a

variety of resources. Staff training was regularly reviewed and updated to keep in line with current best practices, and when we spoke to staff they were able to tell us how they had benefitted from their training.

People who lived at Oaklands told us that they enjoyed the food provided, and we saw that attention was paid to diet and hydration. Day to day health needs were monitored and the service worked well with external health and social care agencies, particularly commissioners and general practitioners (GPs).

Care was delivered in a person centred way by staff who knew the people who lived at Oaklands well, and we saw that all were treated with kindness and respect. People were involved in planning their care, and where they lacked capacity to consent to care and treatment the service complied with the relevant legislation around capacity and consent. All the staff we spoke with were mindful that Oaklands was a person's home. For example they did not place any restrictions on visitors, care plans reflected physical, mental and social needs and people were encouraged to follow activities that they enjoyed. Relationships between people who lived at Oaklands were nurtured and encouraged.

There were few complaints made. The service kept a log of all complaints and recorded all investigations and any actions needed in response to concerns raised about the service.

We saw that attention was paid to people at the end of their lives, and saw a number of cards from relatives thanking the staff for the care provided for people at the end of their lives. However, care plans did not include information provided by people who used the service and their relatives about how they would like to plan for their last days.

Staff and people who used the service told us that the registered manager was approachable, fair and open minded, and we saw that she promoted a person centred culture and good team ethic, encouraging openness and honesty amongst the staff team.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

People told us they felt safe at Oaklands, and the staff understood how to protect people from abuse.

A number of improvements had been made to make the building and environment safe for people to use, and risk assessments minimised the danger of people coming to harm. A new medicines room ensured that medicines could be stored correctly and safely.

There was a high level of staff retention and people who lived at Oaklands were supported by people who knew them well.

Is the service effective?

Good

The service was effective.

People's needs and choices were reflected in care plans and support was delivered in a timely manner.

Staff were well trained and received regular supervision.

People's health and welfare was monitored and checked, with access to a range of health professionals.

People enjoyed the food they were offered.

Is the service caring?

Good

The service was caring.

People were treated with positive regard; all staff treated people with kindness and respect.

People were involved in their care and advocacy was encouraged.

Privacy and dignity were respected.

Is the service responsive?

Good

The service was responsive.

People were central to the planning of their care and care plans reflected their physical, social and emotional needs.

People told us there was enough for them to do, and there was a range of activities on offer each day.

People knew how to complain about their care but there were relatively few complaints.

Is the service well-led?

Requires Improvement

The service was not always well led.

The service did not respond immediately when informed of faulty equipment.

The service had a registered manager who was knowledgeable and respected by the people who used the service.

The service had developed a person centred culture and staff recognised that they worked in people's home.

Oaklands Rest Home Limited

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 7 and 8 December 2017. The first day was unannounced. The inspection team consisted of one adult social care inspector, and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service, specifically working with older people and people living with dementia.

Prior to our inspection we asked the provider to complete a Provider Information Return. This is a form which asks the provider to give us some key information about the service, what the service does well and improvements they would like to make. We also reviewed the information we held about Oaklands, including any statutory notifications submitted by the provider or other information received by members of the public. A statutory notification is information about important events which the provider is required to send to us by law.

During our visit we spoke with the registered manager and deputy manager, three care workers and the cook. We observed how staff interacted with people and spoke with seven people who used the service and three visiting relatives.

We looked around the building, including all of the communal areas, toilets, bathrooms, the kitchen and the garden. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us to understand the experience of people who cannot talk with us. We observed how staff cared for and supported people, and looked at food provision.

We reviewed the care records for five people, four medicine administration records and four staff personnel files and other documents related to the management of the home, such as maintenance records and service invoices.

Prior to our inspection we reviewed the information we held about the service, and contacted the local authority safeguarding and commissioning teams to obtain their views about the service.

Good

Is the service safe?

Our findings

People told us they felt safe at Oaklands. One person who used the service said, "It's lovely here. I feel very safe and well-looked after and it's very clean". Relatives agreed. A person visiting their relative told us, "I feel that [my relative is] safe here, I've never seen anything to concern me. A few years ago, staffing was an issue but staff numbers have improved".

The building was secure; visitors were required to ring the bell, and on entry sign the visitor's book. When we arrived at the home on the first day of our inspection we were asked to show our identity before we were allowed to enter.

People were protected from harm and abuse. Staff told us they had received training in protecting vulnerable adults from abuse and that they would report any poor practice to the manager immediately. The service had procedures to protect vulnerable people and a copy of the local social services safeguarding policies and procedures to follow the local initiative. This meant staff had access to the local safeguarding team for advice and the contact details to report any incidents. Staff were vigilant and watchful for any signs that the people who lived at Oaklands were at risk of harm. The local authority safeguarding team asked that the care home send a monthly report of any safeguarding enquiries and when we reviewed this we saw that there had only been one incident reported since our last inspection. We saw that this was fully investigated and although the allegation was not substantiated the service took steps to ensure the continued safety of the person about whom the allegation was made.

Staff were also aware of the whistle blowing policy and they told us they would report any poor practice. A whistle blowing policy allows staff to report genuine concerns with no recriminations. The staff we spoke with informed us that they were aware of how to pass on any concerns about poor practice and felt that if they were to do so they would be listened to. One care worker we spoke with told us how they had used this policy in the past to pass on concerns that a colleague was disrespectful and abusive to people who used the service. They told us they were frightened nervous when they reported their concerns, but reassured when the service investigated their concerns fully and took the necessary action. This member of staff believed that this incident would encourage all staff to report any poor practice.

When we inspected Oaklands in December 2016 we found that there were problems with the general maintenance of the home. When we conducted a focussed inspection in March 2017, we found that some action had been taken to improve the environment but at the time the premises remained improperly maintained. For example, a frayed carpet identified earlier had not been replaced, and a broken bath panel had not been removed or repaired. At this inspection we saw that further improvements had been carried out and the service was no longer in breach. The carpet in the main lounge had been replaced; the upstairs bathroom had been fully refitted and an unused bedroom close to the manager's office had been converted into a medicine room. New fixtures and fittings, such as curtains and furniture, had been purchased to replace old and worn stock.

However, when we looked in the kitchen area we saw that the seal to the main freezer was worn. This meant

that food stored in this freezer could not be kept at the right temperature. It is important to store food correctly to stop bacteria from spreading and to avoid food poisoning. We asked the cook about the broken seal, and they informed us that this had been identified during a recent Food Standards Agency check, and the home had been told to replace the freezer. When we raised this with the registered manager she told us that she had informed the home owners, but that they had not yet acted on the advice provided. However, she contacted the owners who agreed to replace the freezer immediately, and two days after our inspection we were informed that a new freezer had been delivered.

We looked at maintenance records and safety certificates which were all in order. Electrical installation and gas equipment were checked by external contractors and records kept to show that these were safe. We also saw documentation for the lift, wheelchair, hoist and sling checks, the control of Legionella and portable appliance tests (PAT). This meant equipment was safe for staff and people who used the service. The registered manager showed us a home maintenance register which documented when equipment needed to be checked or replaced.

A fire risk assessment had been carried out and the fire safety officer had provided instruction to staff. The service also conducted regular fire drills, including successful tests of means of escape, firefighting appliances and emergency lighting. Everyone living at Oaklands had a personal evacuation escape plan (PEEP). PEEPs explain how each person would be evacuated from the building in the event of an emergency. A copy of each plan was displayed on the back of bedroom doors with a master file close to the front entrance. These plans were regularly reviewed.

We looked at five care records which showed that risks to people's health and well-being had been identified. These involved risks such as mobility, risk of falls, eating and drinking, communication and hygiene. We saw that where risk had been identified a corresponding detailed care plan was put into place to help reduce or eliminate the identified risks and these were reviewed on a regular basis.

Risks were assessed in relation to each individual. We saw specific risks, such as inappropriate behaviour, or assessment for pain relief had been assessed with instruction to staff to minimise the risk. However, we saw that the wording in one risk assessment regarding anxiety and aggression was ambiguous and could be misinterpreted. We raised this with the registered manager who agreed to amend the wording to clarify the instruction. When we asked staff how they supported this person they were able to explain how they would respond when such incidents occurred and provided a consistent response. Care records indicated that such interventions were kept to a minimum and we observed staff working with this person knew them well, and were vigilant to their mood and needs.

When we looked around the home we saw that steps had been taken to prevent injury or harm. For example, corridors and walkways were free from obstacles. We noticed that the layout of the building did not lend itself to safe care; sharp corners and narrow corridors made navigating people in wheelchairs or supporting people using walking frames difficult. However, we saw that staff were vigilant when offering support in these areas, and took great care when helping people.

We saw that there was a good ratio of staff to people who used the service. Since our last inspection we saw that the number of people using the service had significantly reduced, but there had been no reduction in the number of staff on duty. There was a consistent staff team; most of the staff had worked at Oaklands for five years or more. This meant that staff were familiar with the people who used the service. One visiting relative remarked, "Staff don't change much, which is good. They're relating to [people who use the service] all the time, so there's continuity". We looked at the staff rotas for the previous two months, which confirmed the level of staffing for the service had been maintained. In addition to the manager and deputy

manager, there was a minimum of three care staff during the day, and one senior care worker. Two waking night staff were on duty each night. There was relatively little sickness and any gaps in the rota were covered by regular staff on an overtime basis. The deputy manager told us that they and the registered manager took turns to be on call to deal with emergencies, but informed us that they were rarely called out. They told us, "The night staff are good at their jobs and are well organised. They know what they're doing so they don't need to call us out".

We looked at the recruitment procedures which gave clear guidance on how staff were to be properly and safely recruited. This helped to protect the safety of residents. We looked at four staff records. These contained proof of identity, an application form that documented a full employment history and accounts for any gaps in employment, a job description, and two references. Where necessary, checks were made to ensure that people were eligible to work in the United Kingdom. Checks had also been carried out with the Disclosure and Barring Service (DBS) before the member of staff began work. The DBS identifies any people who are barred from working with children and vulnerable adults and informs the service provider of any criminal convictions noted against the applicant. This meant that checks had been completed to reduce the risk of unsuitable staff being employed at Oaklands.

Senior staff were trained to administer medication, and we observed one medication round during our inspection. The senior care worker checked the dosage and that they were for the right person before approaching the person. They addressed them by name and explained what they were doing. They then checked the person had a drink to help them take the medicines. The member of staff made sure they had swallowed the medicine before recording this on the medication administration record (MAR) sheet.

At the last inspection we saw that medicines were kept in a locked medicine trolley which was stored in the manager's office when not in use. This room had poor ventilation and could become very warm. This could affect the potency of the medicines; if they are stored at the wrong temperature medicines can lose their potency and become ineffective. At this inspection we saw that the service had converted an unused bedroom into a locked treatment room for medicines and that the temperature of the room was checked and maintained at the required temperature.

The Senior Care worker on duty would hold the keys, with a spare set locked in the manager's office. Medicines were dispensed from a lockable trolley using a controlled dose system, which minimised the risk of incorrect dispensing.

Some prescription medicines are controlled under the Misuse of Drugs legislation. These medicines are called controlled medicines or controlled drugs. We saw controlled drugs were stored in a further locked cabinet, and the controlled drug register was checked on a daily basis at the start and end of each shift and countersigned when administered. We checked the balance of controlled drugs for two people and found them to be correct.

MAR Sheets included a photograph of the individual, and noted any intolerance to medicines and allergies. The records we checked were accurate, up to date and matched the medicines in stock. There were no gaps in signatures. There was also a signed log of all returned unused medicines. The registered manager conducted a monthly audit of medicines, including checks for any errors. Where these had occurred, we saw that appropriate measures were put in place to prevent any future reoccurrence.

Nobody who lived at Oakland received medicine covertly. Medicine given covertly is the administration of any medical treatment to a person in a disguised form, such as sprinkled over food. We saw that the service had a protocol in place to respond to a person if they did not agree to take any prescribed medicines,

including consultation with the person, their representative and their doctors, capacity assessments and recording of any decisions made on behalf of the person and would require written authorisation from the person's general practitioner (GP). Similarly, the service had safeguards in place to ensure that any medicines prescribed to be given as required were provided using the correct protocol.

One visiting relative remarked, "[My relative] is always clean and so is the home. It's never smelly; the only thing you can ever smell is food being cooked". We looked at the arrangements the home had in place for the prevention and control of infection. During our tour of the building we saw that toilets and bathrooms contained adequate stocks of soap and paper towels and posters detailing the correct handwashing procedure were prominently displayed. We observed staff used personal protective equipment (PPE), including disposable vinyl gloves and aprons when undertaking care tasks. This helped prevent the spread of infection between staff and people who used the service. Appropriately coloured waste bags were used to identify different types of waste. This ensured that clinical and hazardous waste (waste produced from health and care activities that may pose a risk of infection, for example, swabs, bandages, or soiled pads or continence aids) must be disposed of in a way which prevents cross contamination and must not enter the domestic waste stream.

Communal bathrooms were clean and hygienic. They were decorated in pastel shades that gave a homely feel to them. Thermometers in each bathroom allowed the staff to ensure the water temperature was not too hot or cold. We saw that where dangerous or hazardous equipment was stored doors displayed warning signs and 'keep locked notices'. When we tried these doors, we found that they were locked.

In the laundry, we saw that soiled items were appropriately washed separately from other items of clothing, preventing the risk of cross contamination.

Staff we spoke to understood the importance of infection control measures, such as the use of colour coded cleaning equipment and the use of personal protective equipment such as tabards, vinyl gloves and other protective measures when handling food or completing personal care tasks and cleaning. Wearing such clothing protects staff and people using the service from the risk of cross infection during the delivery of care. Staff had attended infection prevention and control training.

When we spoke with staff they demonstrated an understanding of the importance of safety measures to protect themselves and people who used the service. We saw that when accidents and incidents occurred these were recorded, investigated and actions implemented to prevent future reoccurrence.

Good

Is the service effective?

Our findings

People believed that they were supported to maintain a good quality of Life at Oaklands. "Let's be honest", one relative remarked, "It's not the Ritz, but it's all about the residents here. We wouldn't have her anywhere else. They let everyone be an individual and accommodate them. They let her sleep when she wants and get up when she wants. She's happy here and it's allowed us to have a life by her being here safe and well-cared for. In the last nine months, she's picked up, her mental ability has improved, and her bodily functions are all working. We have peace of mind and can enjoy our family now".

Prior to their admission into Oaklands, the registered manager or deputy would complete a preadmission assessment. Where possible, the person would be invited into the home to give them an opportunity to meet staff and other people who lived in the home, and for the people at Oaklands to have an opportunity to meet them. The registered manager told us, "We've had a lot of enquiries recently, but it's about whether we can meet their needs. A person is coming for their tea on Monday. I've completed an assessment but this will be a chance for them to meet the [people who use the service]. Afterwards I can ask them for their thoughts."

Once a person moved into the service their needs were continually re-evaluated as they became familiar with their environment and the staff who supported them. Throughout their stay people were encouraged to maintain their independence and lifestyle choices. For example, the manager told us that one person had arrived in the care home after a prolonged stay in hospital, and was unable to walk. Working under instruction from physiotherapists and careful and patient support, they had helped the person to regain their mobility. The person's care records demonstrated this gradual improvement. Another visiting relative told us, "[My relative] is well cared for here, she wouldn't be here if not. I was scared that she would be moved into a Nursing Home due to her mobility but the manager reassured me right away".

Staff told us, and we saw from records that when they started at Oaklands they received a full induction and were subjected to a probationary period. They did not work unsupervised until they and their supervisor felt they were competent to do so.

During their induction period all staff completed training in a variety of subjects, such as food safety, infection control, manual handling first aid and safeguarding vulnerable people. The registered manager was resourceful and ensured that staff received ongoing training from a variety of sources to ensure that their knowledge and understanding of how to support people was kept up to date, taking advantage of any training on offer, and opportunities to call on the expertise of others if it would help staff to provide a better service. A training record showed which staff had completed courses and when refresher training was required. Training covered topics such as safeguarding adults, first aid, medication, food hygiene, dementia awareness, pressure relief, eye care and safer people handling. On completion certificates were stored on personnel records. One member of staff we spoke with had recently completed a dementia awareness course and told us how this had helped them to understand the reality of living with dementia, and had helped them to provide a more person centred approach to work with people, taking into consideration how they perceived everyday objects and shapes, which could be seen as a threat. They said, "It gave me a

greater understanding of what it must be like, so I am more aware when I'm working with people who have dementia."

During this inspection we saw that the registered manager kept a timetable which showed that all staff received a supervision session every three months to four months and a yearly appraisal. Supervision meetings provided staff with an opportunity to speak in private about their training and support needs as well as being able to discuss any issues in relation to their work. We looked at four staff supervision records which showed that meetings were productive and staff used the opportunity to discuss issues of concern, identify areas for improvement and reflect on their core values. Where issues of concern had been identified, either by the member of staff or their supervisor, an 'on-going report' was completed to monitor staff performance and identify any improvements in conduct or service delivery. Clear records, signed by both the supervisor and the person being supervised, were kept on the staff file. Staff we spoke with told us they valued the opportunity to discuss their work with a senior member of staff and that it encouraged openness and honesty.

We saw that staff communicated well with each other and passed on information in a timely fashion. All staff attended a changeover meeting at the start and finish of each shift. This helped to ensure that staff were given an update on a person's condition and behaviour and ensured that any change in their condition had been properly communicated and understood. Staff shared information about individual people who used the service and tasks were delegated appropriately and shared fairly.

People told us they enjoyed the food on offer. When we looked at the menus, we saw they offered mainly traditional meals, such as beef hash and dumplings which was the preferred meal on the first day of our inspection, and the cook told us that they ensure each person received at least three portions of fruit and vegetables each day, including salads at tea time. One person said, "They give us good meals. The food's very nice and we get plenty, enough for me anyway," and others comments we received included, "I like the food, it's very good", and "It's smashing". A visiting relative said, "We think the food is very good".

Attention was paid to people's nutrition and hydration needs and when we toured the kitchen we found the larder and freezers were well stocked. The registered manager told us that they always used named brands, ensuring all food purchased was of a good quality. People were weighed regularly and where appropriate a food and drink chart was used to monitor the amount given and the amount consumed. If necessary staff would make referrals to dieticians or speech and language therapists for advice on diet and swallowing. One relative told us "[My relative] was put on a liquid diet which we didn't think was right, so we and the girls here fought to get her reassessed which she was eventually and she's now back on normal foods, well soft foods. She doesn't have any teeth, so she eats with her gums".

We saw when we looked at care records that diet plans were followed, and when we looked in the kitchen we saw lists showed the number of people who required their food to be prepared in a specific way, such as pureed, or mashed. The list also showed the number of people who needed specific diets due to medical concerns such as diabetes, or cultural needs, and personal preferences. One person was a vegetarian and was provided with a meat free alternative to all meals.

As people rose, they were offered a cooked breakfast or could chose cereal, porridge and toast. The main meal was served at lunchtime, with a choice of two main courses followed by a desert. A further meal was provided at teatime, for example, soup and sandwiches, and people were offered supper before retiring to bed. Throughout the day snacks and hot and cold drinks were offered, and people could ask for fresh fruit.

We observed lunchtime in the dining room. Tables were nicely set out with place mats, napkins, cutlery and

condiments, and the menu was displayed pictorially and in writing. The SUs at the start of lunch were offered an option of two juice drinks (orange or blackcurrant cordial). During lunch, there was a calm, relaxed atmosphere. The staff wore linen aprons during lunchtime and then wore plastic aprons to clear up afterwards. Eight people who used the service wore protective aprons after being asked and two had plate protectors. This helped to ensure that food could be collected more easily on the plate and prevent spillage. No-one initially was being supported to eat until one person was encouraged to eat by a staff member who then sat down next to her and helped her to eat. A visiting relative told us about their relative, "Oh, she can eat! She starts off eating herself, but she gets tired so they help her then". We saw there was no rushing; meals were given at the person's pace. Two people ate in the lounge. One wore a protective apron, used a plate protector and ate independently with a spoon. The other ate very independently in front of the TV. This person's lunch was served on a tray, lined with a tea towel with their own condiments. We were informed by the staff that this person was "Fiercely independent and a proud gentleman". One lady ate later "After she had come round"; and another ate in her bedroom because "She is not too well today but she generally prefers it in her room anyway".

People had good access to healthcare and staff monitored their physical and mental health needs. The service had established good working relationships with speech and language therapists to monitor diet and swallowing, and with the community psychiatric team for support to manage people's behaviours. One person who used the service told us that they were seen by the doctor and district nurses when they were ill, and "The doctor came recently, and gave us all a flu jab". Evidence in the case notes we reviewed showed liaison with district nurses, regular health checks and GP visits for example, to monitor skin integrity. We saw in care plans that people had regular access to other treatment such as dentist, optician and chiropody appointments. This meant that people were receiving care and support to access additional health care services to meet their specific health needs.

When we toured the building we saw that a number of improvements had been made to the décor of the building. These included new fixtures and fittings such as curtains and carpets in the main lounge and a number of bedrooms. We saw pictorial signs to help guide people through the building and grab rails in corridors that were of a contrasting colour to the rest of the room. The use of contrasting colours can help people with dementia and sight difficulties find their way around their environment more easily. During our inspection we saw the people who used the service did appear to mix with each other. People who were capable were able to move freely around the home with access to the stairs and lifts.

When we spoke to people and their relatives they told us that they were always offered meaningful choices. One visiting relative told us, "They all know [my relative] very well and if she wants to get up in the night, they get her up and bring her down into the lounge. Nothing is too much of a problem for the staff; it's all about the people they support and what they want to do".

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.

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 Deprivation of Liberty Safeguards (DoLS). By law, the Care Quality Commission must monitor the operation of any deprivations and report on what we find. 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 registered manager told us and we saw information to show that where people lacked the capacity to agree to receiving care and treatment at Oaklands the appropriate applications had been made and authorised by the supervisory body (local authority). We had been notified of these authorisations. Where these were due to expire there was evidence of requests for a review. When a DoLS had been requested or authorised the information was stored within the person's care records, along with details of why the DoLS had been agreed, and any conditions relating to the restriction. We saw that the registered manager kept a separate record to show when a request had been made, authorised, or due to expire. This reduced the risk that the authorisation could expire without the knowledge of the registered manager, and allowed a quick check to determine if the deprivation made was legally permissible.

Capacity assessments had been completed to determine why people needed a DoLS authorisation. When we looked at the care records we saw evidence of best interest decisions which indicated why the service was applying for a deprivation of liberty in the person's best interest. This helped to make sure that people who were not able to make decisions for themselves were protected.

Good

Is the service caring?

Our findings

Throughout our inspection we observed staff being kind, patient and respectful to people who used the service and people who lived at Oaklands told us that they were well cared for. One told us, "The staff are really good, they're always chatting to me and they're there if I need anything. We're all well looked after". And another said, "It's good here, and the staff are nice. They always have time for me". When we spoke with a visiting relative we were told, "[My relative] is well cared for here, she wouldn't be here if not. I was scared that she would be moved into a nursing home but I was reassured right away. The manager knows everyone here and the carers are just lovely and very attentive".

Another visitor said to us, "It's very welcoming and all the staff are very friendly. On shift change, all the staff always say hello to all the [people who use the service] and visitors". When staff interacted with people they were caring and compassionate. We noticed that staff called all people by their first names or preferred names, and when we spoke with staff they talked about individual people with knowledge of their backgrounds, likes and dislikes, as well as their current individual needs and behaviours. Throughout our inspection we saw that all staff made time to sit and chat with the people who lived at Oaklands and knew them well. We saw one person who used the service had developed a warm and friendly relationship with the cook. As staff learnt more about the people who lived at Oaklands, useful information was added to their care plans, for instance, in one care plan regarding food and drink a comment had been added, "Loves Turkish delight".

The staff we spoke with showed a good understanding and knowledge of the people who lived at Oaklands, and care was person centred. We noticed that staff would begin to arrive some time prior to the start of their shift, and those finishing work would stay beyond their hours. People were treated by staff with positive regard. One care worker we spoke with told us, "I enjoy looking after them, they are my family. It is their home, and I am here to assist. Whatever they feel like doing, we will try to do".

When we looked in care files we saw that these included a good pen picture of each individual, including important milestones and people in their life. Added detail reflected a sound knowledge and understanding of the person acknowledging their likes, dislikes, cultural needs and values. When we talked with staff they were able to show an awareness of the people who used the service which reflected the written information. This meant that the service was person centred and based on the person's needs and wishes.

We saw that staff understood and respected the level of support people needed so people were involved as far as possible in decisions about their care and how it was delivered. For example, we noticed that after lunch, one person remained in the dining area and was still not eating their food. We asked if this needed to be warmed up, but were told that this person enjoyed eating slowly and liked to let their food cool right down before they ate. This was reflected in their care plan. They were later joined by another person for whom their meal had been kept back. This person told us that they had had a lie in and a late breakfast so they were not hungry earlier.

Care records reflected if the person had a legal guardian or if a relative had power of attorney to help make

decisions regarding financial or welfare matters. People had access to independent advocates if they were required; an advocate is a person who can represent the person to ensure that any decisions taken about the person are in their best interests. When we reviewed care records we saw that relatives' wishes were recorded, but where these might be at odds with the needs of the person who used the service, we saw that the views were considered before a decision in the best interest of the individual was made with all interested parties involved in the discussion. However, the focus of care remained firmly on the needs and wishes of the person using the service, we saw that care was person centred, and the staff and management strived to provide a service which was in accord with peoples wishes. For example, the family of one person were placing demands which the person did not agree with. Although acceding to the family's request would have been an easier option for the staff, they recognised the person's right to make their own decisions and advocated to support them to follow their own choices. We also overheard a member of staff advocating for an individual who was unwell. The member of staff phoned the person's General Practitioner (GP) who was initially reluctant to do a home visit, but the care worker was able to persuade them of the urgency. The GP visited within the hour, and made the necessary arrangements for medical care for the person.

We saw that people who used the service were clean and dressed appropriately, well presented, and men were clean shaven. Staff were also vigilant to people's appearance, for instance we observed staff discreetly adjusting people's clothing to maintain their dignity.

Information held about people, including all care records were securely stored in locked offices when not in use. This helped to protect the personal information held about people who used the service. Staff had access to the notes and we saw that they regularly consulted care plans and assessment to ensure that they were providing appropriate care and support.

During our inspection there were a number of visitors to the home, and the staff knew who they were and who they were visiting. There was a friendly atmosphere and visitors were encouraged to make friends and take an interest in the other people who used the service. We were told that there were no restrictions as to when people could visit and that if they wishes, relatives could stay over, if their relative was unwell or if they had travelled some distance to visit.

Good

Is the service responsive?

Our findings

The people we spoke with told us that the staff at Oaklands were mindful of people's welfare and quickly responded to changing needs. However, they did not always inform relatives promptly. One visiting relative told us, "Two weeks ago, [my relative] fell. They rang for an ambulance and she went into hospital and we were contacted too. Normally, they always tell us about any medication changes from the doctor but this time the hospital changed it, she's on blood thinners now and we didn't know until [the manager] told us this week". Another told us, I'm happy overall and there've been some improvements over the past year. They don't always phone to inform me of doctor's visits, so communication could be a bit better. Just as an example she was put on protein shakes because she wasn't eating, and it was 2 weeks before I was informed, and I don't actually know if she's still on them. It depends which staff are on really but the Manager's OK. I'm not concerned about her well-being at all though".

We looked at five care records. Each began with personal information about the person and included an up to date photograph so that anyone unfamiliar with the service would recognise the person. Information about each person was detailed and written in a person centred way focussing on their abilities and strengths. The care records contained detailed information to guide staff on the care and support to be provided. They also showed that risks to people's health and well-being had been identified, such as the risk of poor nutrition and the risk of injury. Where a risk had been noted action to reduce or eliminate any identified risk was recorded in detail. Charts were completed to record any staff intervention with a person, such as recording food and fluid intake, and when staff turned a person in bed where there was an identified risk regarding pressure areas.

One file we reviewed showed that the person did not have a history of falls. However, following a recent fall out of bed, a full risk assessment considered ways to minimise the risk, including a referral to the falls co-ordinator. Staff considered whether the person's poor cognition may have been a factor in this incident, and moved the position of their bed to see if this would help to avoid a repeat occurrence.

We saw evidence that all plans had been reviewed when required and on a monthly basis, and saw staff were vigilant to changing needs. Daily notes gave a good indication of how the person had responded during the shift and included observations about any changes in behaviour patterns. One case note we saw identified a person was having trouble orientating themselves around the building and suggested all staff assist with orientation. When we looked in care plans we saw they reflected these changes and provided instruction on how to respond. A care worker told us, "If we notice anything it gets discussed at the handover meeting. We all sit down together and discuss people's needs. We tell [the registered manager] what has changed and she amends the plans. Care plans can sometimes change a couple of times each week, so we watch. I've noticed [a person who uses the service] is leaning to the side today, we'll keep an eye on it and follow up if necessary".

From our observations and discussions with the registered manager and staff it was apparent that some of the people who used the service did not have the capacity to be involved in the planning of their care. We saw that this was reflected throughout the care files and capacity and consent issues were clearly recorded

with a rationale as to why this was in their best interest and recording the views of their relatives.

Where people did have a greater understanding of their needs and how they could be best met people were encouraged to voice their opinions, and people we spoke with agreed that they had been involved in reviewing how their care was delivered.

When we inspected Oaklands in December 2016 we found that the service did not provide enough activity or stimulation for people who used the service, which was a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. When we returned in March 2017 we found some improvement, and at this inspection we saw that the improvement had been maintained. People who used the service and their visitors told us there had been more stimulation. One person who used the service said, "There's been improvements with the entertainment, they've always had music but there's singing and crafting now, and there's a party for every festival". Visiting relative told us, "Just lately, well this year, there's been more entertainment, [visiting performers and singers], bingo, painting pot pigs. There's a Christmas Party this Sunday and they had a Halloween Party. I think there's enough stimulation for them. [My relative] doesn't want to join in, but likes to watch. The hairdresser's been in this morning to do their hair".

Although they did not employ an activity co-ordinator, all staff took responsibility to arrange activities and pastimes on a daily basis, and when we spoke with people who used the service they told us that they felt staff took an interest in them and help to keep them stimulated. They also told us that there were regular activities organised for people who wished to join in. We observed a bingo session on the first day of our inspection, and people participating enjoyed this activity. There was a choice of prizes to be won which were displayed on one of the tables and the individual chose their own prize.

A weekly activities rota was displayed and a Christmas Party being advertised. Relatives were invited to attend and an entertainer had been booked.

There was also a notice that a visiting pastor visited on the first Thursday of each month for Holy Communion. No-one arrived on the day of inspection (which was the first Thursday of the month) but when we inquired we were told by staff that they were coming the week before Christmas instead. We were also informed by staff that the priest and pastoral people also come to visit one of the people who used the service on a regular basis.

A service user guide given to all residents with a copy in their care files explained how to make a complaint, to whom and how it would be dealt with. In addition the complaints procedure was on display in the reception area. We looked at the complaints log and saw that there were no outstanding complaints, and only one complaint had been received since our inspection the previous December. We saw this had been appropriately dealt with, with written evidence of investigation and conclusion.

When we looked at care plans we saw that they included some information about how people would like to be supported at the end of their life and noted if the person expressed any wishes in the event of their death. Where appropriate a 'do not attempt resuscitation' form (DNAR) signed by the person's GP was kept at the front of the person's file. A DNAR form is a document issued and signed by a doctor, which advises medical teams not to attempt cardiopulmonary resuscitation (CPR). We saw that some staff at Oaklands had completed training in the six step end of life care model. This course aims to ensure that high quality, person-centred care is provided which is well planned, co-ordinated and monitored, while being responsive to the individual's needs and wishes. Staff who had attended this course told us they had benefitted from the training. One person said, "We do everything we can to make them comfortable, paying attention to their food and hydration needs, and other things such as mouth care. We liaise with family and outside

agencies to make their dying as comfortable and pain free as we can. We saw thank you cards and compliments from relatives of people who had lived and died at Oaklands, one stated, "All the staff were caring, but the care you showed to [our relative] over the time she spent in bed was second to none".

Requires Improvement

Is the service well-led?

Our findings

During previous inspections at this service we found that there had been a lack of financial investment, which had led to a number of concerns regarding the overall governance of the service. Staff had not always been paid on time, and it was to their credit that they continued to work despite the threat that they would not be paid. They told us that they were there to support the people who used the service, and would not want to let them down. At this inspection they confirmed that their wages had been paid into their accounts as scheduled. We saw that a number of improvements had been carried out to improve the environment. All old window frames had been replaced, and new fixtures and fittings including carpets and a new bath had been purchased. A room which had previously been used as a bedroom had been converted to provide a safe room for storing and administering medicines. When we inspected in March 2017 the registered manager was using an outdated computer which meant that she was unable to use the resource effectively to plan and deliver the service, or maintain contact with other stakeholders. At this inspection we found that the owners had replaced this with a more up to date lap top, which meant that the manager could effectively store information electronically and plan service delivery.

However, we found that the freezer used to store frozen food in the kitchen area was damaged. The owners were made aware of this following an inspection by the food standards agency, but did not take any immediate action. We accept that following our inspection the freezer was replaced, but the owners did not immediately recognise their responsibility to ensure the safety of people using the service, or follow the recommendations of the Food Standards Inspection.

We recommend that the service responds in a timely and appropriate way to advice regarding safety measures from external inspections and reviews.

Oaklands had a written philosophy of care which stated a commitment to providing high quality individualised care, in a safe friendly and informal atmosphere. We saw the staff and managers lived up to this commitment, and there was an inclusive family feel during our inspection. A visiting relative told us, "I come most days and I think it's brilliant. It's very friendly and it feels very comfortable to visit".

The statement of purpose for the home stated the aim was to "Maintain and if possible improve a service user's quality of life". Staff encouraged people to maintain their independence, we observed a person wanted to walk from the lounge to the bathroom without their frame, and a member of staff walked with them, slightly in front to prevent any accident and encouraged them to walk unassisted, but ready to provide support as the person tired.

It is a requirement under The Health and Social Care Act that the manager of a service like Oaklands is registered with the Care Quality Commission. When we visited the home had a registered manager who has been registered since 2015, having previously worked at the service for eight years. The registered manager was present throughout the inspection.

Everyone we spoke with held the registered manager in high regard. A care worker told us that, "The

manager is very good, she listens to staff and supports them, we are a happy team thanks to [the registered manager]".One person who used the service said, "The Manager's very good indeed". They told us, and we saw that the registered manager was visible around the home every day when on duty. She showed a clear understanding of her role and was aware of her responsibility to pass on any concerns about the care being provided, including notifications to the CQC and local authority commissioners.

People were equally complimentary about the staff. The deputy manager told us, "We have a really good set of staff, they work really well. They don't need much correcting and are all good at their jobs, they've worked together for seven years, so they know each other, and more importantly they know the [people who use the service]". A visiting relative told us, "The staff and the Manager are always available if I want to talk to them". We saw staff at Oaklands understood their role and were conscious of their relationship with the people who used the service, recognising that this was where they lived. We saw that staff worked well together. We asked them about their relationship with one another. One care worker told us, "We have the usual moans, but we never forget we are here for [people who use the service]. It is their home, they need some support, and none of us ever forget that. We are here for them". The positive culture of the service was reflected in the interactions we observed to encourage people who used the service to maintain their independence and listen to them as well as providing support.

We saw the service had recently reviewed their policies and procedures and had invested in a package of policies produced externally, and tailored to respond to the needs of the people living at Oaklands. These policies were accessible to all staff, and included information about culture and beliefs to ensure fair access to services for all people. The registered manager showed us a policy relating to Rastafarianism, she told us that, although they did not have any Rastafarians living at Oaklands at this time, they would know how to respond should the need arise. When we spoke to staff they gave a good indication of how they support people from different backgrounds to their own. One told us about a person whom they supported who came from an Eastern European culture, and told us how they had learnt from working with this person about their culture and traditions.

The relatives of residents we spoke with told us that they were kept informed of any changes in their relative's condition and felt comfortable about contacting the service. One told us, "We come Tuesday, Thursday and Saturday and they're always available to talk to us and update us on what she's been up to". We saw any communication with relatives was recorded in care files.

When we asked people if they were invited to meetings we were told they were not. One visiting relative told us, "I don't think there's any Relatives Meetings or at least I've never been invited to one". We asked the registered manager about this. She told us they did not hold meetings, although they had done so in the past but these were poorly attended. They had asked people who used the service and their relatives why and were informed that they did not want it. However, she told us "Now I have a lap top computer I am beginning to draft a regular newsletter to keep people informed of what is happening here". Relatives told us, "There's no Relative Meetings but we don't need them, we just ask, or they tell us what's going on, and they always ring us with any concerns".

We saw that there were quality assurance processes in place, such as audits which helped the manager of the service review and monitor its standards. The service left satisfaction questionnaires available for people and their visitors to complete. Where people had difficulty they were assisted to complete the forms, which were audited every six months. We saw that an analysis of the last satisfaction questionnaire had resulted in some suggestions around food and activities being implemented.

The registered manager showed us the systems in place to monitor the quality of the service to ensure

people received safe and effective care. Regular audits/checks were undertaken on all aspects of the running of the service. She completed regular audits around staffing, training, resident issues, care plans, activities, nutrition, incidents, and medicines. In addition she monitored cleaning schedules, weight charts, and food and fluid charts to ensure that these were completed in accordance with good practice guidelines. Where mistakes occurred these were addressed.

The service worked well with local stakeholders and actively sought support and collaboration with relevant external agencies. It had responded to constructive criticism; for example recommendations following a recent quality assurance visit from the local authority had been followed up, and the service had completed an action plan to improve the service. Before our inspection, we checked with the local authority commissioning team and safeguarding team, and they informed us that they did not have any concerns about Oaklands.

The registered manager was aware of when notifications had to be sent to CQC. These notifications would tell us about any important events that had happened in the home. Notifications had been sent in to tell us about incidents that required a notification. We used this information to monitor the service and to check how any events had been handled. This demonstrated the registered manager understood their legal obligations.