Crescent Care Limited

Oakland Grange

Inspection report

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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

Oakland Grange is registered to accommodate up to 43 people who require personal care. At the time of the inspection, 42 people were living at the home. The home is based on four floors with two interconnecting passenger lifts and an ample choice of communal areas where people could meet and spend their day. All bedrooms had en-suite facilities.

The inspection was conducted on 19 and 20 October 2017 and was unannounced. There was a registered manager in place. 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 our last inspection, in September 2016, we identified breaches of Regulations 13 and 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Bruising to people was not always investigated or reported to the local safeguarding team; and the quality assurance systems were not always effective. At this inspection we found action had been taken. There were no longer any breaches of these regulations and quality assurance processes had been enhanced. However, some further improvement was required in other areas.

Staff sought consent from people before providing care or support and acted in their best interests. However, people's capacity to make specific decisions was not always recorded and decisions that staff had taken on behalf of people were not always documented to show why they were in people's best interests.

People felt safe living at the home. Staff knew how to identify, prevent and report abuse. They assessed and managed most risks to people effectively.

Arrangements were in place for the safe management of medicines. People received their medicines as prescribed.

There were enough staff to meet people's needs in a timely way. Appropriate recruitment procedures were in place and pre-employment checks had been completed fully before staff started working with people.

People's needs were met by staff who were competent, trained and supported in their role. People's dietary needs were met and they received appropriate support to eat and drink enough.

People were supported to access healthcare services when needed. The home was taking part in a pilot project with other professionals to help reduce unnecessary hospital admissions.

People were cared for with kindness and compassion. Staff knew people well and supported people to maintain relationships that were important to them.

Staff protected people's privacy and dignity. They encouraged people to remain as independent as possible and involved them in planning the care and support they received.

People's needs were met in a personalised way. Each person had a care plan that was centred on their needs and reviewed regularly. Staff empowered people to make choices and responded promptly when people's needs changed.

People had access to a meaningful activities based on their individual interests, including regular access to the community. They knew how to make a complaint and a complaints procedure was in place.

People and their relatives felt the service was run well. There was a clear management structure in place. Staff were organised, motivated and worked well as a team. They enjoyed working at the home and told us they felt valued.

People described an open culture where visitors were welcomed at any time. Staff enjoyed positive working relationships with external professionals and positive links had been developed with the community.

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 felt safe and staff had received training in safeguarding adults. Individual risks to people were managed effectively.

Arrangements were in place for the safe management of medicines and people received their medicines as prescribed.

There were enough staff to meet people's needs and recruitment practices helped ensure only suitable staff were employed.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff did not always record assessments of people's capacity or decisions made on their behalf. However, they acted in people's best interests and sought verbal consent before providing care and support.

People received effective care from staff who were suitably trained and supported in their roles.

People were supported to have enough to eat and drink. They had access to health professionals and specialists when needed.

Is the service caring?

Good

The service was caring.

Staff treated people with kindness and compassion. They interacted positively with people and promoted their independence.

Staff supported people to maintain relationships that were important to them.

Staff protected people's privacy and respected their dignity.

People were involved in planning the care and support they received.

Is the service responsive?

Good

The service was responsive.

Care and support were centred on the individual needs of each person. Care plans were reviewed regularly and staff responded promptly when people's needs changed.

People were empowered to make choices about all aspects of their lives. They had access to a range of meaningful activities suited to their individual interests.

People knew how to raise a complaint and there was an appropriate complaints procedure in place.

Is the service well-led?

Good

The service was well-led.

People were happy living at the home and had confidence in the management.

People described an open culture. Visitors were welcomed at any time and there were positive working relationships with external professionals. Links had been developed with the community to the benefit of people.

Staff were organised, motivated and worked well as a team. They felt supported and valued by their managers.

A quality assurance process was in place to assess and monitor the service. People and staff were involved in developing the service.

Oakland Grange

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 was 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 19 and 20 October 2017 and was unannounced. It was conducted by an 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.

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 the improvements they plan to make. We reviewed the information in the PIR, along with other information that we held about the service including previous inspection reports and notifications. A notification is information about important events which the service is required to send us by law.

During the inspection, we spoke with 10 people living at the home and six visiting family members. We also spoke with a director of the provider's company, the registered manager, the deputy manager, seven care staff, an activity coordinator, a cleaner, a chef and a maintenance person. We received feedback from a community nurse who had regular contact with the home and a social care practitioner from the local safeguarding team. We looked at care plans and associated records for seven people, staff duty records, recruitment files, records of complaints, accident and incident records, and quality assurance records.

We observed care and support being delivered in communal areas of the home. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

Good

Is the service safe?

Our findings

People told us they felt safe at Oakland Grange. One person said, "I feel quite safe, I don't have any worries." Another person told us, "[I feel] very safe with the personnel who are helping us." A family member echoed these comments and said, "I feel when I leave here I don't need to worry about [my relative]. I know they're safe here."

At our last inspection, in September 2016, we identified a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as unexplained bruising to people was not always investigated or reported to the local safeguarding team. At this inspection, we found action had been taken and there was no longer a breach of this regulation. There was now a clear process in place, which staff understood, for any injuries to people to be recorded, investigated and reported. Staff had refreshed their safeguarding training and knew how to protect people from the risk of abuse. They were confident that managers would respond to any concerns raised. A social care practitioner from the local safeguarding team confirmed that managers cooperated fully with any investigations and took appropriate action to protect people from the risk of abuse.

People were supported to receive their medicines safely. One person told us, "They [staff] are very strict when it comes to your tablets." A family member said their relative's medicines were "managed well" by staff. All medicines were administered by trained staff whose competence was checked yearly by one of the managers. Information was available to guide staff when administering 'as required' (PRN) medicines, such as pain relief and sedatives, to help ensure these were given in a consistent way. People told us they could access PRN pain relief when needed. One person said, "If you tell them you have a headache, they'll bring you a tablet." Staff also knew how people preferred to take their medicines; for example, they described how one person liked a glass of water placing in their hand and another liked to take biscuits with their tablets.

Medication administration records (MAR) confirmed that people had received their oral medicines as prescribed. In addition, staff recorded when they applied topical creams to people. There was a system in place to help ensure topical creams were not used beyond their 'use by' date in accordance with the manufacturers' guidance. This required staff to date the creams when they were opened, although we found this was not done consistently. We discussed this with the registered manager and they took action to remind staff to do this. They also modified their medicines audit tool, so this would be checked as part of the medicines auditing process.

Individual risks to people were managed effectively. Risk assessments had been completed for all identified risks, together with actions staff needed to take to reduce the risks. For example, some people were being cared for in bed, so were at risk of developing pressure injuries; they had been provided with pressure-relieving mattresses and, where needed, were also being supported to re-position regularly. Other people had swallowing difficulties and were at risk of choking on their food and drinks. They had been referred to speech and language therapists and staff were following their recommendations, for example by thickening people's drinks to a specified consistency or softening their meals.

People who were at risk of falling had been given walking aids. Staff made sure these were accessible and prompted people to use them correctly. When people experienced falls, their risk assessments were reviewed and additional measures considered to keep the person safe. As a result of one review, we saw a sensor mat had been put in place to alert staff when the person got out of bed. Staff also respected people's right to take informed risks where they had the capacity to do this; for example, one person chose to propel themselves in their wheelchair, even though they could be unsteady when doing this. Staff were aware of the risk and monitored the person discreetly so as to respect the person's choice. The registered manager reviewed all falls in the home on a monthly basis to identify any patterns or trends; none had been identified, but they described the action they would take if a common theme emerged.

Most environment risks were managed appropriately. However, the maintenance person told us they did not check the temperature of hot water outlets in people's rooms as they relied on pre-set mixer valves to adjust the temperature to a safe level. We checked three of the outlets and found the valves were not adjusted correctly and were delivering water above the recommended temperature, which put people, particularly those living with dementia, at risk. The maintenance person undertook to check and adjust all the valves and the registered manager added this task to the monthly audit process as an added safety measure. Other risks posed by the environment were managed appropriately. Three people smoked cigarettes and risk assessments had been completed to support them to do this safely and in a suitable place. Fire safety systems were checked regularly; staff were clear about what to do in the event of a fire and had been trained to administer first aid. In addition, each person had a personal emergency evacuation plan detailing the support they would need if the building needed to be evacuated.

There were enough staff deployed to meet people's needs. One person told us, "The response time is very good." Other people said staff were sometimes busy in the mornings, but call bells were always responded to within "five to ten minutes", which they felt was sufficient. A family member told us, "I'm surprised at how many staff are around. I come in at any time and there's always someone around." The registered manager used a dependency tool, based on people's needs, to help calculate the number of staff needed at different times of the day and duty records showed these levels were met consistently. Staff absence was covered by existing staff working additional hours, which meant people were cared for by staff who knew them well.

Appropriate recruitment procedures were in place and followed. These included pre-employment reference checks and checks with the disclosure and barring service (DBS). The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services. Staff confirmed these processes were followed before they started working at the home.

Requires Improvement

Is the service effective?

Our findings

Staff protected people's rights by following the principles of the Mental Capacity Act 2005 (MCA), although assessments and decisions were not always recorded in accordance with the MCA Code of Practice. The 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 decisions made on their behalf must be in their best interests and as least restrictive as possible.

During the care planning process, managers had assessed people's capacity to make specific decisions, such as to receive medicines, to use an alert mat or to have a modified diet, although they had not used the standard two-stage test specified by the MCA Code of Practice. Following the assessment, staff had made best interests decisions on behalf of people, but had not recorded how they came to the decision or why the decision was in the person's best interests. Family members told us they were involved in decision making, but we found their views had not been recorded as part of the best interests process. We discussed this with the registered manager and by the end of the inspection they had developed a new form to help record the MCA assessment and decision making process. They assured us they would complete the form for each person retrospectively to review whether the best interests decisions they had made were still valid.

Staff described how they sought verbal consent from people before providing care and support and said they were led by the person and acted in the person's best interests. A staff member said, "We act in the best interests of residents and what is best for them. If they have capacity, we have to accept decisions; we don't judge them." One person told us staff "always ask my permission". A family member told us, "[Staff] don't force anything on people; they are good at going away and trying again later and [my relative] responds to that."

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. We found the provider was following the necessary requirements. Some people had no restrictions in place and could come and go as they pleased. A family member told us, "I like the fact that they let [my relative] have his freedom, which keeps him happy." Other people, who would not be safe if they left the home without support, were subject to DoLS authorisations. All but one of the conditions attached to people's DoLS authorisations were being complied with. In respect of one person, the registered manager was seeking clarification from the local authority about the most appropriate way to meet one of the conditions that had been imposed.

People's needs were met by staff who were competent and suitably trained. One person said of the staff, "They look after you well all the time." A family member told us, "Staff here are incredible. I trust that [my relative] is well looked after and I've been pleasantly surprised." Another family member said, "We are

incredibly pleased with the way [my relative] is looked after; for example, she had a [skin ailment] and staff have controlled it very well."

Records showed staff received regular training in all relevant subjects. These were delivered through e-learning, where the pass mark had been set at 100%, or through face-to-face training sessions. In addition, a dementia specialist nurse had started working with staff to enhance their understanding of how to meet the needs of people living with dementia. One staff member told us, "We've had to stop putting white fish with white sauce and white potatoes on a white plate as we had training. We realise now that [people living with dementia] can't see it, so we are getting coloured plates and vary the colour of the food to make it stand out."

New staff completed an effective induction into their role. This included time spent working alongside experienced staff until they felt confident they could meet people's needs. Staff who were new to care were supported to complete training that followed the standards of the care certificate. The Care Certificate is an identified set of standards that health and social care staff adhere to in their daily working life. Experienced staff were supported to gain vocational qualifications relevant to their role. One staff member told us, "I am doing a [vocational qualification] at the moment. I am really happy as it is developing my skills." Another staff member said, "We are encouraged to improve ourselves and get better every day; I love the training, all of it."

Staff demonstrated an understanding of the training they had received and how to apply it. For example, we observed they used equipment correctly when supporting people to move. When communicating with people living with dementia, they used short, simple, open questions, remained calm and gave people time to respond. A family member told us, "Staff cope well with [my relative's] dementia. They are very supportive more than anything; they try to find out what is making her upset and use open questions."

Staff told us they felt supported in their roles. Comments from staff included, "If I have a problem I go to [one of the managers]; they are always available"; "The managers are really, really supportive"; and "We have supervisions, but I talk to [the managers] all day long. They're always there, even out of hours. They make us feel free to call them and they answer straight away." Staff had annual appraisals where they discussed their performance and development needs, together with three-monthly sessions of supervision, with a supervisor or manager, to discuss their progress and any concerns they had. During their appraisal, one staff member had requested additional training in palliative care and we saw this had been arranged. The registered manager described how they helped staff who needed extra support by giving them opportunities for extra training, mentoring and pairing them up with more experienced staff.

People were complimentary about the food. Comments included: "Meals are very good. They [staff] come round with the menu and if I don't like what's on the menu they do something else, like scrambled eggs"; "It's wonderful; so fresh everyday"; and "It's all good. Too good as I've been eating too much! So I've been skipping some dinners, but it's my choice."

Choices were offered for all meals; for example, we saw four different breakfast options and three lunch time choices. To support people living with dementia, staff used pictures of the meals to help them choose. Then, at the point of service, people were also shown the plated-up meals to make it easier for them to confirm their choice. Alternatives were also offered if people did not want anything from the menu; for example, one person did not eat their meal and we heard staff tempted them with snacks, sandwiches and yoghurt. People had access to a variety of drinks at all times. One person told us, "I have juice. If I need coffee or a cup of tea they [staff] will bring it; you just need to ask."

Staff were attentive to people at meal times and provided support when required. For example, one person needed full support to eat and drink and received this on a one-to-one basis in a dignified way. Other people just needed prompting or encouraging to eat. One person was known to become restless at mealtimes and chose not to spend long at the table, so staff gave them smaller meals more frequently to suit their preference. Another person preferred to eat with staff, and we saw a staff member made a point of sitting with the person and eating a snack to encourage the person to eat more of their meal.

Staff monitored people's weight and took prompt action if they started to lose unplanned weight. For example, their meals were fortified with extra calories and they were offered additional snacks. Where necessary, people were also referred to their GP so prescribed food supplements could be considered. People's care records showed these measures had been effective in supporting them to maintain a healthy weight.

People were supported to access healthcare services when needed. One person said, "If I don't feel very well, I tell the staff and they arrange for my own doctor to come in." Records confirmed that people were seen regularly by doctors, specialist nurses and chiropodists. In addition, the home was taking part in a multi-agency project aimed at avoiding unnecessary admission to hospital. The project included weekly meetings with staff, community nurses, occupational therapists, a pharmacist and a GP to review people who were at risk of becoming unwell. We observed part of one of these meetings and found staff were well-informed about the health status and needs of everyone discussed. A community nurse linked to the project told us, "Staff are passionate and enthusiastic. They are engaging well with the project and coming up with good ideas. I'm very impressed by their commitment." The project also provided training for care staff to enable them to check people's blood pressures, blood sugar levels and oxygen saturation levels so healthcare professionals could diagnose problems more quickly by telephone.

Good

Is the service caring?

Our findings

People were supported by kind, caring and compassionate staff. Everyone we met spoke positively about the attitude and approach of staff. Comments from people included: "Staff are very good. If I want anything, they get it for me"; "They have the patience of Job; they are all so good"; "It's the people that matter and they [staff] are good people"; and "[Staff] are very caring because they look after us and treat us well".

A family member said of the staff, "What I see is caring staff. They are more compassionate, caring and patient than I could ever be. They support me as well as [my relative]; I have a laugh with them." Another family member told us, "They are incredibly caring; they know [my relative] really well. She responds to a smiley face and touch, which they give her." A further family member said, "All staff are very friendly, I am happy because I can go home and relax with the assurance that [my relative] is well looked after."

Without exception, all interactions we observed between people and staff were positive and supportive. Staff demonstrated that they knew people well; for example, they asked about their family members and talked to people about their previous occupations. They engaged with people, made eye contact, bent down to their level and used touch appropriately to reassure. When people became confused, staff used supportive prompts and gentle reminders to help people process information and make decisions. When a person appeared cold, a staff member offered them a blanket and said, "You've got to keep warm, it's nearly winter." When another person stopped to speak with staff, the staff member noticed they were looking dishevelled, so they gently supported the person to straighten their shirt and smooth their hair; they reassured the person they looked "lovely and smart" and the person went away with a smile on their face.

Staff supported people to build and maintain relationships that were important to them. A double-sized room was not available for a married couple living at the home, so staff had turned a single room into a double bedroom and an adjacent room into a sitting room with a television. This replicated the arrangements the couple were used to before moving to the home and allowed them to remain close. For another married couple, staff had organised a party for a key wedding anniversary to which all their family and friends were invited, together with local dignitaries. One of the couple told us, "It was a heck of a do. The chef made a cake, so we all had a nice party; we even had the music person. We were thrilled to bits, it really was special."

Staff protected people's privacy and dignity at all times. One person told us, "They [staff] are very good at respecting my privacy." Another person said they used a lock that had been fitted to their door "all the time" to protect their privacy. A quiet lounge was available for people to meet friends and family in private. We saw staff always knocked before entering people's rooms and kept doors closed while personal care was being delivered. When talking about a person with advanced dementia, who had lost the capacity to communicate verbally, a staff member told us, "[The person] is unable to make decisions; but we always talk to them, even though they can't respond. It's about dignity. We explain what we are going to do and how we are going to do it. We look at their face and make eye contact to reassure them."

The registered manager explored people's cultural and diversity needs during pre-admission assessments

and included people's specific needs in their care plans. For example, they were aware that one person chose not to eat meat; another person preferred female only staff for personal care; and a further person had chosen not to discuss their sexuality. A staff member told us, "If [the person] wants to keep their sexuality confidential, then that's fine. It's not for us to probe."

People were encouraged to remain as independent as possible in line with their abilities. For example, their care plans specified tasks they were able to perform for themselves and those they needed support with. One person told us, "If I'm a bit wobbly, they [staff] help me wash; otherwise, they let me get on with it." A staff member confirmed this and said, "To support independence, we don't automatically do everything for people; for example, we will stand aside and they will let me know if they need help."

People and relatives told us they were involved in discussing and making decisions about the care and support they received. One person said, "If I have an accident, they phone my family and keep them in the loop." A family member said of the staff, "They take a collaborative approach. They take note of our wishes and share what's going on openly and honestly. We've had a big conversation about end of life care. We've been through the care plan with staff; there's nothing hidden here." Another family member said, "The managers keep me up to date with [my relative's] care, but don't burden me with minor concerns." Information in people's care records confirmed that they, and family members if appropriate, were consistently involved in developing and reviewing their care plans.

Good

Is the service responsive?

Our findings

People told us they received personalised care and support that met their needs. One person said, "[Staff] are led by me and help me with what I want." A family member told us the care was "consistent and [my relative] seems to like it here." Another family member said, "[My relative] is very happy here. Her anxiety level has [reduced] ten-fold."

Assessments of people's needs were completed by a senior staff member, in conjunction with one of the managers, before people moved to the home. This information was then used to develop an appropriate care plan in consultation with the person and their relatives where appropriate. A senior staff member told us, "We gather information from a range of sources including the social worker and hospital staff if the person is coming from hospital. We always base the care plan on what the person wants at that time. The family are very much involved at every stage, if the person agrees." One person, who had moved to the home recently, had started behaving in a way that put themselves and others at risk. Staff had liaised with the person's relatives and explored a number of strategies to support the person at these times, including spending time with the person on a one-to-one basis. They had also worked with the person's GP and a mental health professional to identify an appropriate medicine to help calm the person.

Care plans contained sufficient information to enable staff to provide appropriate care to people and were reviewed monthly or sooner if people's needs changed. Staff demonstrated an in-depth understanding of people's individual needs and how to meet them. For example, they described how they supported different people with personal care and how they tailored their approach according to the person's preferences and how they presented that day. Staff kept records of the care and support they provided to people. These confirmed that people's needs, as outlined in their care plans, had been met consistently. For example, they included 'turn charts' for people who needed support to reposition regularly and charts to record the fluid input and output of people with catheters.

Staff responded promptly when people's needs changed. For example, where they identified that a person's catheter was not draining well, they sought advice from a community nurse. Similarly, where people showed signs that they may have an infection, staff conducted tests and consulted with the person's GP. One person told us, "I was confused this morning, but [a staff member] helped me." A family member said, "If [my relative] has a problem, he will go to the office and he will be helped." A staff member told us, "People's [needs] change all the time, so we need to make sure we do what they want."

Staff promoted choice and empowered people to make as many of their own decisions as possible. One person told us, "You do what you want, it's up to you." We repeatedly heard staff offering choice and giving people time to reach decisions. A staff member told us, "I always ask what help [people] want. Regardless of their dementia, they still have the right to choices." People said they could choose whether to have their doors opened or closed; whether they had baths or showers and how often they had them. One person told us, "They [staff] usually ask, 'Do you want to do this or that?'. They don't force things on you." Another person said, "I prefer a shower and [the staff] get it ready for me at exactly the temperature I like." People could also choose how and where they spent their day and where they took their meals. Some people

preferred to remain in their rooms, while others spent time in the lounge or dining room. One person told us, "I usually have my breakfast in my room and lunch downstairs; it's my choice, it's up to me."

People had access to a range of meaningful activities suited to their individual interests. We observed a number of activities during the course of the inspection, including bingo, quizzes and trips to the local shops which people clearly enjoyed. Some people preferred to remain in their rooms and staff spent time with them on a one-to-one basis, engaging them in an activity or reminiscence. One person living with advanced dementia was unable to respond to activities, but records showed a staff member "sat on [the person's] bed and stroked their hand while listening to their favourite music". People also told us they were supported to access the local community; for example, one person said, "They [staff] take me out for a bit of retail therapy." Another person said they enjoyed visiting local coffee shops with staff.

People told us they felt able to raise concerns or complaints with the management, although most had not had cause to and no complaints had been recorded in the previous year. One person said, "You can go to the office and they will take [your complaint] up." A family member echoed this and said, "If I have a concern, I email [the registered manager], but all the staff are approachable and if anything happens they ring me." A complaints procedure was in place. A copy was given to people and their relatives when they moved to the home and was also advertised on the home's notice board.

Good

Is the service well-led?

Our findings

At our last inspection, in September 2016, we identified a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as quality assurance processes were not always effective. At this inspection, we found action had been taken and there was no longer a breach of this regulation.

The quality assurance process had been improved and included structured audits of areas such as care plans, infection control, medicines, accidents and incidents. The registered manager was responsive to issues we identified during the inspection to further enhance the quality assurance processes. For example, they updated the care plan audit to help ensure mental capacity issues were considered and updated the health and safety audit to help ensure water temperatures were routinely checked.

Quality issues were also discussed at monitoring meetings between the registered manager and a director of the provider's company. The director completed weekly visits when they spoke informally with staff and people living at the home; they also completed monthly audits of key aspects of the service, including sampling of care plans, health and safety issues and staff training. The implementation of improvements identified during the audits was monitored through the use of an action plan and the meetings programme. For example, the flooring was being replaced throughout the home and this was due to be completed the week after our inspection and a further project, to upgrade the call bell system, was also being explored.

People were happy living at Oakland Grange, felt it was well-led and said they would have no hesitation in recommending it to others. One person told us, "[The registered manager] and all the team are brilliant." Another said, "I'm really happy with the service and everything they do for me." A family member told us, "I can't fault the place. It's always very organised and staff are very attentive." Another said, "I have full confidence in the home. It's a happy place. There's always laughter; staff clearly enjoy working here." A community nurse who had regular contact with the home told us, "The home is very well-led. It's well organised. The managers are excellent. I'm very impressed."

The registered manager sought feedback from people and family members, including through the use of questionnaire surveys, informal meetings and a 'comments book' kept in the entrance lobby. Everyone we spoke with felt they were listened to and that their feedback was taken seriously. One person told us, "I've just talked to a [senior staff member]; they listened." Another said, "I put my five eggs in when we have meetings and I definitely feel listened to." The feedback was used to help improve people's experience of the service. For example, a family member told us, "I mentioned that [my relative's] room looked tired, so they got fresh carpet, new curtains and decorated; just like that."

The registered manager kept up to date with best practice guidance by maintaining their training and developing links with managers of other homes, including through the local care homes association. The registered manager told us, "[Since the last inspection] I've done training in risk assessing, falls, safeguarding and recording of bruising."

People and relatives described an open and transparent culture within the home where they had ready access to the management at all times. A family member told us, "We can visit at any time; there are no restrictions. They [staff] have created a nice atmosphere." The provider notified CQC of all significant events and the home's previous inspection rating was displayed prominently. External professionals told us they enjoyed positive working relationships with staff.

A duty of candour policy was in place; this required staff to act in an open and transparent way when accidents occurred and to provide information and an apology in writing to the person or their relatives. However, we found this was not followed fully. Although the registered manager had been giving information and apologies verbally to relatives, they had not been providing the information in writing, due to an oversight. By the end of the inspection, they had developed a template letter which they assured us they would use in the future to provide the required information to people in writing.

Staff had developed links with the local community to the benefit of people. For example, a local supermarket had raised £1,000 to develop the home's garden to make it more accessible to people. In addition, pupils from a local high school visited the home to interact with people as part of a Duke of Edinburgh award scheme. Staff told us these visits were popular with people and said they were the only time one person could be persuaded to leave their room as "they love the children coming".

There was a clear management structure in place consisting of the provider, the registered manager, a deputy manager and senior care staff. A director of the provider's company regularly spent time in the home and we saw they interacted positively with staff. The management structure had proved to be robust as the service had managed to operate effectively during the intermittent absence of the registered manager due to unavoidable personal circumstances. At these times, the deputy manager ran the home with the support of a director of the provider's company and senior care staff.

Staff were organised, motivated and worked well as a team. They felt supported and valued by the management. Comments from staff included: "Team work is good and the work flows well between day [staff] and night [staff]"; "I'm very happy in my work; it suits me well"; "There is good management. The owner rings and asks how we are. He actually cares about me"; "Morale is good. There's a brilliant team; we all work together like a little family"; and "The manager is so supportive. The team is brilliant; we all work well and support each other".

Communication between staff was effective and helped ensure key information about people was passed from shift to shift. This was helped by a 15 minute overlap between each shift, during which a 'handover' meeting took place. A staff member told us, "There is good communication between the team. We share information so we all know what's going on and make sure [people] are properly cared for." Another said, "The handovers are very useful. We talk about everyone in detail; you need that information, it's essential."

Managers also sought feedback from the staff team. Staff meetings were conducted regularly. These were used to reinforce key messages and learning from incidents; they also provided an opportunity for staff to suggest improvements that could be made. A staff member told us, "I would say we are listened to. For example, if we feel an alarm mat is needed and it's not in the care plan, we suggest it and get what we need for people."