Bournemouth Care LLP

Great Oaks

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This unannounced comprehensive inspection took place on 14 and 15 June 2018. This was the service's first inspection since registering in June 2017.

Great Oaks is registered to provide accommodation, nursing care and support for up to 80 people. At the time of the inspection there were 36 people living at the home. The home provides accommodation over three floors. Bedrooms had en-suite toilet and shower facilities and communal areas included small kitchenettes, dining rooms, lounges and separate quiet rooms for people who wished to spend time quietly. There were also specialist bathrooms and an easily accessible garden. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

There was a registered manager employed at the service. 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.

Medicines were not always stored and managed safely. Medicine fridges had been running for 48 hours at temperatures outside of their safe range and although staff were aware this had happened, action had not been taken to address the error and make medicines safe. Inconsistencies were identified in the management of fluid thickening agents and medicine administration records including topical cream administration records were not completed consistently.

These shortfalls were a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff were aware of what constituted abuse and the actions they should take if they suspected abuse. Relevant checks were undertaken before new staff started working at the service which ensured they were safe to work with vulnerable adults.

Staff had the right skills and training to support people appropriately. Staff had completed or were in the process of completing The Care Certificate, which is a nationally recognised set of standards for health and social care workers. The provider ran a detailed training programme for all staff, which staff told us they found useful and effective.

People and staff consistently told us there were not enough staff on shifts to care for them appropriately. The registered manager confirmed they were in the process of recruiting further staff for an additional position that would increase the staffing levels.

Staff told us they felt overwhelmed and felt the use of supervision meetings were used in a negative way. They said the management team did not listen to them and felt they did not receive effective support.

Supervision meetings for staff were not completed consistently. This area for improvement had been identified by the provider who told us a revised schedule of supervisions would be put in place.

People's care records were not consistently completed. Records had omissions, some had inaccurate information recorded and were illegible.

These shortfalls were a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Pre-admission assessments were completed prior to people moving into the home. People's risks were assessed and plans developed to ensure care was provided safely. Accidents and incidents were monitored to ensure any trends were identified to enable action to be taken to safeguard people.

People were referred to health care professionals as required. If people needed additional equipment to help them mobilise and keep them safe and comfortable this was readily available.

The manager was aware of their responsibilities regarding the Deprivation of Liberty Safeguards (DoLS). These safeguards aim to protect people living in care homes and hospitals from being inappropriately deprived of their liberty. These safeguards can only be used when there is no other way of supporting a person safely. Staff understood the Mental Capacity Act 2005 (2005) and how it applied to their work.

Staff knew people well and cared for them with warmth and compassion. We observed staff supported people in a friendly and caring way and treated people with dignity and respect. People had their privacy respected.

People had positive meal time experiences and enjoyed nutritious, appetising meals. People were offered choice for their meals and told us they really enjoyed the food they were offered.

There was a range of meaningful activities for people to participate in if they wished.

The systems in place at the home had not identified the shortfalls we found during our inspection in relation to medicine management and record keeping. This led to a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were plans in place for the provider to form active links with the local community.

There were effective systems in place to ensure the safety and maintenance of the premises.

You can see what action we told the provider to take at the back of the full version of the report. Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Medicines were not always stored, administered and managed safely. People were not always protected against the risks associated with the unsafe management and use of medicines.

People and staff consistently felt there were not enough staff available to support people safely.

Staff knew how to recognise abuse and what actions to take if abuse was suspected.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff did not feel well supported and did not always receive appropriate supervision.

People's care records were not always completed consistently or accurately.

Staff received effective training and understood the requirements of the Mental Capacity Act.

There was a good choice of nutritious, appetising food and drink that people could access when they liked.

People had access to a range of healthcare professionals as appropriate.

Is the service caring?

Good

The service was caring.

Care was provided with warmth and compassion by staff who treated people with respect and dignity.

People and relatives told us staff were kind, caring and patient.

People's confidentiality was respected.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People's care plans were not always up to date and accurate.

People knew how to raise a concern if required and felt they would be addressed promptly.

The service made good use of technology to support people.

People had their end of life wishes respected.

Is the service well-led?

Requires Improvement

The service was not always well led.

Governance systems were ineffective and had not highlighted weaknesses in shortfalls in some areas.

Staff felt overwhelmed and unsupported.

People's care records were inconsistently completed.

The provider had made links with the local community.

Great Oaks

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008. The aim was to also look at the overall quality of the service, review the improvements as had been agreed following the last inspection and to provide a rating for the service under the Care Act 2014.

This comprehensive inspection took place on 14 and 15 June 2018 and was unannounced. On the first day the inspection team was made up of an inspector, an assistant inspector and a specialist nurse advisor. The second day of the inspection was carried out by one inspector and an assistant inspector.

Before the inspection we reviewed the information we held about the service. This included information about incidents the provider had notified us of and a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We also asked the local authority who commissions the service for their views on the care and service given by the home. We requested written feedback from a selection of health professionals who visited the home on a regular basis.

During the inspection we met with most of the people living at Great Oaks and spoke with those who wished to speak with us. We spoke with the operations and quality director, the registered manager, the learning manager, six care staff which included the two nurses on duty, the chef, a visiting district nurse and seven relatives.

We observed how people were supported and reviewed every person's medicine administration record (MAR), five people's topical cream administration records, ten people's care, treatment and support records. We also looked at records relating to the management of the service including staffing rota's, seven staff recruitment records, seven staff training and supervision records, premises maintenance records, accident and incident information, a selection of policies and audits and quality assurance systems, reviewed complaints and compliments and reviewed staff and resident meeting minutes.

We used the Short Observational Framework for Inspection (SOFI). This is a way of observing care to help us

understand the experience of people who could not talk with us. We also made general observations, including watching the delivery of care and support in the communal areas of the home.

Requires Improvement

Is the service safe?

Our findings

We received mixed views from people, relatives and staff regarding the safety of people living at the home. We asked people if they felt safe and they replied, "Oh yes" and "Yes of course". However, some people and staff felt there were not enough staff available to always support people safely. One person told us, "If I need help, they come when they can; sometimes it is quite short staffed. They are struggling with the amount of staff, everything else is spot on." One relative told us, "They could do with more staff at times." Another relative said, "They could do with more staff at weekends and in the mornings." A further relative told us, "There are not enough staff on, it's very short staffed."

We received written feedback from a healthcare professional that stated they felt the home was under staffed and frail and vulnerable people were not always supervised as well as they might be.

We asked staff if they felt people living at the home were safe. One member of staff told us, "Yes, only just though, because the staff are so caring, but there is not enough staff to meet the needs of the people." Another member of staff replied, "Not all the time, no." A further member of staff replied, "Not really no, because we don't have the staff." Staff told us they had sufficient staff available when they had their full allocation of staff on their floor, however they stated this did not always happen. One staff member said, "There's more staff today, if it's the norm when you're here (referring to CQC) why can't it be the norm everyday".

Staff told us they had raised their concerns about the shortage of staff in team meetings and supervision sessions with their line managers, but they regularly did not have enough staff to support people safely. One member of staff told us, "It makes me feel angry and upset because the residents aren't getting the care they need." Staff told us when they raised concerns with the management team, regarding lack of staff, they were told that they were not short staffed and they were just having a busy day. Staff told us they did not feel listened to and regularly felt overwhelmed.

We discussed these concerns with the registered manager. They confirmed there had been challenges with staffing levels which they were managing. They said they had an ongoing recruitment process for recruiting staff and they told us the provider had a staffing dependency tool that gave an indication of what staffing levels would be considered safe, which they were adhering to. They said they covered short term staff absence from within their own staff team before using a staffing agency to ensure the best continuity of care for people. They explained the provider was in the process of creating new roles with more responsibility to distribute the workload between the staff. For example, the provider had plans to introduce a care practitioner role that would be able to support the nurses in their daily duties.

Staffing levels within the home is an area for improvement. We recommend the provider takes measures to ensure there are sufficient staff, with the relevant experience available, to ensure people are cared for and supported safely at all times.

The provider had a process in place to ensure their recruitment procedures were safe. Before staff were

employed at the home, the required employment checks had been carried out to make sure staff were suitable for their role. These checks included, a photograph of the member of staff, proof of their identity, employment references, a health declaration, psychometric tests to assess the suitability of the person for their role, full employment history and a check with the Disclosure and Barring Service to make sure staff were suitable to work with people. If a nurse was being recruited, records were held of the nurse's qualification certificate and checks had been made to ensure their registration was still valid.

The provider had a system in place to ensure that accidents and incidents were identified, investigated and reviewed. Actions were put in place to mitigate risks, which were recorded on the home improvement plan to ensure lessons could be learnt and the risk of re-occurrence reduced. We discussed the reasons why people fell with the operations director. They told us they discussed individual instances of falls with the deputy manager and staff. There were plans to schedule a specific falls training course for all staff; this would raise awareness and ensure staff received a good standard of understanding of prevention of falls.

Staff had attended safeguarding training and understood their responsibilities for protecting adults from abuse. Accident and incident reports were reviewed and analysed and subsequent safeguarding concerns were raised to the local authority and notified to CQC where appropriate. Staff told us they raised any safeguarding concerns to the Deputy Manager who then raised them with the appropriate authorities.

Staff knew about the term 'whistleblowing' but not all staff were able to tell us how they would raise concerns under the company's whistleblowing procedure. Some staff could recall discussing whistleblowing during their induction training but told us they felt their concerns would not always be listened to, even if they did raise concerns. This is an area for improvement.

There were effective measures in place to ensure the safety of the premises. Specialist independent contractors were employed to carry out fire, gas, water and electrical safety checks. Regular health and safety checks were also carried out by the provider. Maintenance records showed equipment, such as fire alarms, extinguishers, and emergency lighting were regularly checked and serviced in accordance with the manufacturer's guidelines. The provider completed preventative actions such as flushing infrequently used taps and descaling showerheads to mitigate the risk of legionella. Legionella are water-borne bacteria that can be harmful to people's health.

The provider had made arrangements to deal with emergencies. Staff had received training on how to react if there was a fire and spoke positively regarding the training they had received. Staff told us and we observed people had Personal Emergency Evacuation Plans (PEEPs) completed for them. These records gave basic information on how people would need to be supported in the case of an emergency such as a fire.

Medicines were not always stored, administered or managed safely. The provider had two new medicine fridges. These were used for the storage of medicines that required storage at a specific temperature to ensure they remained effective. The safe temperature range for a medicine fridge is between 2 and 8 degrees centigrade. We checked both medicine fridges and observed the fridges did not have integral thermometers. Staff told us due to this reason, two thermometers had been purchased specifically for the new fridges but only one thermometer could be located. Records showed one fridge had been operating outside of the safe temperature range for the storage of medicine for over 48 hours. The temperature had been recorded by staff at 16 degrees centigrade but no action had been taken to rectify the concerns or remove the medicines stored in the fridge and replace them. There were people's medicines in this fridge that could be rendered ineffective due to the high temperatures that had been experienced. We immediately raised this concern with the registered manager who arranged for the pharmacy to be contacted and replacement medicines

ordered as required.

Some people were prescribed thickening agents (powders) to add to their drinks to reduce the risk of them choking. There was a risk the wrong amount of thickener could be used because of the lack of clear instructions for staff about how much to use and which scoop to use for measuring. We observed two different thickening agents were in use, each thickener had different mixing instructions and included specific measuring scoops. We observed three different types of scoop in use at the home; each one differed in size and colour and when used would add different amounts of thickener to a drink. However, only one container of thickener had clear instructions for staff on which scoop to use. The remaining containers did not have any instructions for staff.

Instructions for administering the thickener in people's care plans and Medication Administration Record (MAR) were vague. We asked three staff about their understanding of the use of thickening agents and which scoop was the correct one for each thickening agent. Two members of staff were not able to demonstrate a clear understanding of how to administer the thickener correctly. The remaining member of staff demonstrated a clear understanding how safely to administer the thickener to people.

We reviewed all people's medication administration records (MAR). Some people had brought their own medicines with them into the home. These medicines had to be added to people's MAR by staff handwriting the administration details onto the MAR. To ensure safety and accuracy hand transcribed entries on MAR require two staff signatures to ensure they have been checked for accuracy. Not all the handwritten MAR had two signatures to show a check had been done. One handwritten MAR did not have any signature recorded. Some MAR had entries crossed out and amended but were not signed or dated by staff when this had occurred. One person had been prescribed opiates for pain relief; the dose had been altered but there was no staff signature, date or time recorded for the alteration. Some handwritten MAR were illegible.

Staff told us nobody living at the home required their medicine to be administered covertly in their food or drink either crushed or disguised in their meals. However, one person had explicit instructions recorded on their MAR that they required their medicines to be administered covertly. This was conflicting information and could be confusing for staff. We spoke to a member of staff who confirmed the person was no longer having their medicine covertly but this information had not been updated in their MAR and care plan.

Some people were administered time specific medicines to ensure they were safe and effective. Where people required time specific medicines, for example to manage symptoms of Parkinson's disease, these were administered accurately and at the correct time. However, one person required medicines to be administered in six hourly intervals. Timings of administration were not recorded and stated morning, lunch, evening and bedtime. This meant there was an interval of eleven hours between some administrations. Action had not been identified to correct this and ensure the person received their medicine in equally divided timed doses.

The MARS showed some omissions, but the provider's audit process had not identified these. For example, one person had no record of having their Alzheimer's medicine administered on two consecutive days. and there was no indication that this had been followed up. The provider had recently changed their pharmacy, this was the second change of pharmacy for the service since the home had opened in June 2017. People's cream records recorded all topical administration but they did not always reflect the instructions for administering cream to people with pictorial body maps. These topical administration records were inconsistently completed. Some people had many gaps and omissions in their topical administration records, which meant there was a risk these people had not had their cream administered as prescribed.

For people with diabetes who required insulin injections the injection site had not been recorded. This meant there was a risk the same site would be over used and cause soreness and reduced effectiveness of the medicine.

The above weaknesses and shortfalls in the proper and safe management of medicines constitute a breach of Regulation 12 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The stock of medicines had been correctly recorded in the medicine book. People had their allergies recorded and guidance on the use of 'PRN' as required medicines was recorded. Most people were able to tell staff if they needed pain relief. If people were unable to verbalise their pain levels, staff used an independent pain management tool to advise them if people needed additional pain relief. Staff who administered medicines to people had received training in medication administration and received regular medicine competency checks.

Staff had access to personal protective equipment (PPE) such as gloves and aprons. We saw anti-bacterial hand gels were readily available for all people to use throughout the premises. Staff told us they received infection control training and explained what infection control and prevention meant to them. Staff were able to explain how and when they wore their PPE, when they washed their hands and their appropriate use of laundry bags and clinical and waste bins for the different types of waste.

Housekeeping staff told us they were well supported in their role and received appropriate training to ensure the home was kept hygienically clean. We visited the laundry and saw all laundry was placed on a hot/boil wash to ensure bacteria would be killed and the risk of cross contamination reduced. The laundry was orderly and well maintained with a clear flow of dirty to clean items to ensure risks of cross contamination were reduced.

Requires Improvement

Is the service effective?

Our findings

We received written and verbal feedback on the effectiveness of the service from health professionals who had limited contact with Great Oaks. They commented, "The member of staff who assisted me on the assessment was very knowledgeable and interested in guidance and advice we could offer… the home was clean and calm and the person I visited appeared very happy". Another healthcare professional told us, "We hardly ever need to come in, we are called in for specific advice and the staff follow our advice. I've never had any cause for concern, the staff are caring and know the residents well." However, we received differing views from a health care professional who had frequent, regular contact with the service; they felt the effectiveness of the service was generally impaired due to the shortage of staff and trained nursing staff did not receive appropriate support to fully use their clinical skills and judgements.

Before people moved into Great Oaks they had a pre-admission assessment. This assessed their individual care and support needs and led to completion of specific risk assessments that covered a range of areas such as mobility, nutrition and skin integrity. Each pre-assessment led to an individualised care plan for the person which included how they would like to have their support and care delivered and what was important to them. Care plans identified risks to people such as absconding risks, eating and drinking, weight management, wellbeing, mobility and falls and pressure care and gave guidance for staff to follow.

People had access to call bells and knew how to use them. We observed call bell alarms were going almost continuously in the morning, either by people asking for staff support or staff requiring additional support from other staff. The noise from the alarm call system was obtrusive and could be clearly heard throughout the home. We asked one person about the alarms; they said, "They are always ringing, all the time." We discussed this with the registered manager who showed us their electronic call bell alarm response monitoring record. This showed alarms were in frequent use however, the majority of call bells had been answered by staff in under five minutes. They also told us the service was investigating the use of a mobile pager system for staff. If implemented this would greatly reduce the level of noise from call bells and alarms.

Staff had the skills and knowledge to deliver effective care and support. Induction included an introduction to the service and mandatory training including, but not limited to: manual handling, fire safety, and safeguarding. Staff completed shadow shifts with experienced staff before starting to support people on their own. Staff were then reviewed every six weeks to check their understanding and competency. We spoke with the service's learning manager who showed enthusiasm and passion for their role.

Training was delivered through a variety of methods that included; face to face practical courses, one to one refresher training, small group sessions and the use of both Great Oaks internal training team and independent training consultants. Staff employed for the first time in care were completing the Care Certificate. The Care Certificate is a nationally recognised set of standards expected of staff working in health and social care. One member of staff told us, "They're very good with their training, if someone wants to do something they will arrange it."

The learning manager told us about the specific dementia 'mind the gap' training that would be

implemented for all staff. This would ensure a detailed understanding for staff of how people living with dementia would require their individualised care and support. The provider had a leadership programme for staff who wished to advance their career to take part in.

Staff told us and records showed that staff had supervisions, which they referred to as 'job chats'. These were an opportunity to sit down with their manager to discuss their performance, future aspirations and training needs. Staff told us job chats had historically been perceived as a punishment but staff were being encouraged to see them as a positive. Some staff told us they didn't feel they could use these as an opportunity to raise concerns and other staff members told us they could raise concerns but did not feel the job chats were effective; they said, "No one listens." Some staff said they could not remember the last time they had received a job chat and one member of staff told us they had never had a job chat despite working for Great Oaks for over a year. We identified that people had received their job chats however, these were not frequent and did not adhere to the Great Oaks company policy. This is an area of improvement that had already been identified by the service. There was an ongoing action plan in place to address the non completion of staff supervisions.

Completed staff job chats showed that staff had raised concerns, which included; being unable to take breaks, increasing workloads, the low morale of staff and staff feeling consistently short staffed. The responses to these concerns were not recorded on the job chats we reviewed. We discussed our findings with members of the management team. They told us they were trying to increase staff numbers and had introduced new staff roles to distribute the work.

There was a system in place to ensure people were transferred between services smoothly, for example, if people had to move temporarily into hospital. Staff completed a 'transfer form' for each person which included their personal details, recent medicines and any specific medicine requirements, communication, mobility, eating and drinking and their individual personal care needs.

We spent time talking with the head chef and observed the Food Standard Agency had awarded Great Oaks the top rating score of five following their inspection in April 2017. This meant Great Oaks had fully met recognised standards of food hygiene and safety. The head chef knew people who lived at Great Oaks very well and took time each day to sit with people to discuss their likes and dislikes. The kitchen staff were aware of people's dietary requirements including any allergies and how they preferred their meals to be prepared. The head chef was aware which people may be at a risk of malnutrition and those who easily lost weight and had come up with an innovative and enjoyable way to provide extra calories and hydration in the form of Wellbeing Smoothies. Each floor was provided with one fortified smoothie to boost calories and one smoothie to boost hydration each day. Smoothies were made to the recipes the head chef had created. Flavours included, chocolate, peanut butter and mixed melon and staff signed records to confirm which ones they used daily to make sure people didn't inadvertently have the same one every day.

We observed a lunchtime. The dining area was laid out to allow people to sit in small groups or eat on their own if they preferred. The dining room was airy and bright. There was soft music playing in the background, which people enjoyed, and menus on each table. Most people were able to eat their meals independently, however for people who needed assistance staff provided this in a sensitive and supportive way. Staff sat down at the table with people at their level and gently and patiently encouraged them to eat their meal. Staff knew people well and used their preferred name when addressing them. They checked people had finished their meal and whether they wanted a different choice or would like some more. The meal was served by the head chef and assistant chef from a hot plate in the dining room. People were asked what they would like to eat and were given a choice of meal and a variety of fruit juices. Current guidance for people living with dementia recommends people are shown the choice of meals on plates that are brought to them.

This ensures they can make informed decisions about their meal and do not have to remember their food choices, which could prove difficult for people with impaired memory function.

Staff were aware of people's dietary needs and preferences and their food was prepared for them in a manner which was safe for them to eat. For example, if people needed their food to be cut into smaller pieces staff supported them with this or if they needed a 'soft' diet their food was mashed to ensure it was soft and safe for them to swallow. People's meals were served to them on coloured plates, which is a recognised good practice for people living with dementia as they are able to see their food more clearly. Some people were using plate guards that enabled them to eat independently, which was important to them. Cakes, biscuits and fruit were available throughout the day and we observed staff offering people hot or cold drinks and a variety of fruit juices.

People had access to a range of healthcare professionals based on their health and social care needs. Records showed people received care from community nurses, speech and language therapists, occupational therapists, opticians, GP's and chiropodists.

We reviewed people's fluid monitoring records. Completion of fluid records was inconsistent. Some people's fluid records had not been totalled up at the end of each day. This could mean it would be difficult for staff to know if people were at risk of dehydration. Some people needed frequent re-positioning to prevent their skin breaking down and becoming sore. We checked peoples re positioning records which were inconsistently completed. One person's care plan stated they needed re-positioning every four hours. Their repositioning records were incomplete with some entries for some days only showing one repositioning in 24 hours. Another person required regular re-positioning to manage an existing skin integrity concern. Their re-positioning records had regular gaps in the recording, some gaps were up to 11 and 15 hours. Some people had previously had pressure sores which had now healed, however care records did not reflect this and had not been updated. People were generally in good health, therefore the inconsistencies and shortfalls identified were because of poor completion of records.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because accurate records were not maintained.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. Staff demonstrated an understanding of MCA and making best interest decisions. Staff training records showed that staff undertook regular training and competency assessments in the Mental Capacity Act 2005. Staff spoke knowledgably about making use of the least restrictive practices, issues concerning consent and ensuring people were given choice as far as possible.

Senior staff were aware of their responsibilities in regard to the Deprivation of Liberty Safeguards (DoLS). These safeguards aim to protect people living in care homes and hospitals from being inappropriately deprived of their liberty. These safeguards can only be used when there is no other way of supporting a person safely. The responsibility for applying to authorise a deprivation of liberty rested with the senior nursing staff. A number of people who were living at Great Oaks had a DoLS in place and some of these included a range of specific conditions placed on their DoLS. For example, 'to offer the person a range of activities and record their responses in their daily care plan notes.' Other conditions imposed included, 'recording in daily care records when specific people asked to leave the premises' and 'complete detailed life histories for individuals which included their background, likes, hobbies and interests and supporting

people to go out to get a newspaper. ensure the person was supported with regular visits to communal areas.' We reviewed all the DoLS that included specific conditions and saw they had been followed and recorded correctly as specified.

We observed people moving around the home. For people with restricted mobility there was a lift that took them to each floor. Bathrooms and toilets had grab rails in place to assist people in maintaining their independence. Dementia consultants had been employed to design and decorate the home in bright homely colours that contrasted clearly to make it easier for people living with dementia to distinguish bedroom doors and toilet doors. Bedrooms were personalised with people's own furniture and bed linen and pictures and photographs. People had personalised memory boxes outside their bedroom doors which were illuminated to make it easier for people living with visual impairments to see and recognise the room as their own. People had easy, safe, access to pleasant gardens, which they could tend to and grow plants and vegetables if they wished. There was a gardening club people could join which provided practical and social enjoyment for people.

Spacious, bright bistro areas were available for people to sit in with constant access to hot and cold drinks and a variety of nutritious snacks and fruit. During our inspection we observed people and their relatives and friends enjoying these facilities, laughing and talking with visitors, staff and other people living in the home. One relative told us, "It's great to have these areas… so nice to sit and chat and share a drink."

Good

Is the service caring?

Our findings

People and relatives, we spoke with told us they were happy living in the home. They told us staff treated them with kindness, warmth and compassion. A visiting health professional told us, "The staff are very caring and know all the residents very well. I am always welcomed and they work well together." A relative told us, "It has been wonderful, so much better for my husband. He can wander around safely and go into the garden and sit for a chat with people anywhere." Another relative told us, "The staff know [person] so well, they are all caring and kind." Everyone we spoke with commented on the kindness shown to them by staff; comments included, "They have hit every button, it's so welcoming, they couldn't do enough for us... they went above and beyond in supporting us."

Written feedback from a health professional commented the staff always did their best to deliver compassionate care but staff had complained that they did not have the time to administer to their clients as fully as they would wish.

We observed staff were cheerful, kind and treated people with patience and understanding. Staff interacted with people in a friendly way and used their preferred names when addressing them. Staff knew people well and how they preferred their care and support to be given. One member of staff told us they loved working at Great Oaks even though they found the staff shortage difficult. They told us they all worked well together as a team, they said, "We're like a family." They said they liked to do their job to make sure people were happy and smiling. People appeared happy, looked well cared for and spent time talking and laughing with others.

Staff talked with people appropriately, speaking with them at their eye level and checking they understood them before offering any support or care. However, staff told us they often did not have enough time to spend with people and felt they were always rushing from one person to another, which did not give them any opportunity to spend quality time with people. During our inspection we spent time observing staff and people in the communal areas. Staff supported people in a friendly way but did not spend time sitting with them or chatting. People who wanted to, spent time chatting to each other or with their relatives and watching television.

People or their relatives were involved in planning their care and lifestyle in the home. Records showed people's views and preferences for care had been sought and were respected. Some people were in the process of having their records updated. Where people's records had been completed they included people's life story, their childhood, their previous working lives and interests. Records showed what was important to people now and their likes and dislikes. This information was useful for staff to get to know the person well and provide activities they enjoyed.

The provider had an equality and diversity policy and provided staff with equality and diversity training. People had their privacy and dignity respected. We observed staff knocked on bedroom doors before entering people's bedrooms and ensured bedroom doors were closed when personal care was being delivered. Staff told us they made use of towels to maintain people's privacy and ensured people's clothes

were appropriately arranged when transferring them by hoist from their bed to their chair. People and their relatives told us staff respected their wishes and they were treated with respect and dignity by all the staff.

There were smaller communal rooms available for people to use if they wished to sit in a quieter area. People and relatives told us they really enjoyed these areas which they made use of frequently. One relative told us, "We really enjoyed coming in and using the little break out lounges. They were so thoughtfully designed there is always somewhere to go." The smaller rooms could be used by families for special events such as birthdays or family meals, which gave families privacy for people to enjoy their event.

Requires Improvement

Is the service responsive?

Our findings

We received mixed views from health professionals who visited the home. Comments from health care professionals included, "The staff follow our advice well, people are looked after well." Another health professional told us they felt due to the general shortage of staff, staff actions tended to be reactionary rather than proactive or anticipatory.

Other than commenting negatively on the levels of staff available, relatives spoke positively about the level of care their relative received at Great Oaks. One relative told us, "There is nothing I would have changed, I can't fault anything."

Care plans contained extensive information about people, but were not always consistent in their information, up to date or did not contain important, specific information. For example, one person had poor eyesight and speech problems; these details had been recorded in their pre-admission assessment but not included in their care plan. People had mobility plans for staff to support them with their mobility. Mobility plans we reviewed were vague. For example, there was no information about how many staff were required to help a person mobilise. the level of support they needed or prompts regarding their poor vision. There was no specific guidance for staff in the care plan or on any handover sheet reminding staff of this person's sensory loss. Another person was identified as at a high or very high risk of falls. Their mobility care plan did not include guidance for staff on how best to support and assist this person. Care plans referred to hoisting people but did not give guidance on the sling size or detailed guidance for staff on how to attach the sling safely to the hoist. People's care information was often located in a number of different documents stored in different places. The service used agency staff to cover for staff absence and with the inconsistencies we found in care plans there was a risk staff may not have clear direction on how to provide specific care, support and treatment to meet people's personal and nursing needs.

We recommend the provider addresses the inconsistencies in people's care plans to ensure accurate, up to date information and guidance is included for staff to follow.

There was a schedule of daily activities throughout the day. The registered manager told us the activities co-ordinator had recently left the service and another member of staff had stepped in to cover the duties while the recruitment process for a replacement activities co-ordinator was underway. Activities covered a wide range of subjects and included visits from independent entertainers, musicians and the opportunity to take part in quizzes, puzzles, singing sessions and gentle exercises. The service also had a pet cat who was a favourite among people who lived there. Staff told us how the garden had been designed to allow for people to join in and take part in any light gardening they wished to do. The garden was easily accessed and had a selection of raised beds to allow people to grow vegetables and herbs. One person was sat in their bedroom listening to their radio; we asked them if they enjoyed this, they replied, "Oh yes, I always like to keep it on, it's lovely and cheery music, it varies so it's nice."

We reviewed how the provider ensured people had access to the information they needed in a way they could understand it, to comply with the Accessible Information Standard. The Accessible Information

Standard is a framework put in place from August 2016 making it a legal requirement for providers of NHS and publicly funded care to ensure people with a disability or sensory loss can access and understand information they are given. Although, staff were aware of the communication needs of the people they supported, information in some people's care plans was not always up to date. Staff told us about what help and support could be offered through appropriate referrals to external agencies, such as large print books, audible listening books and keyboards with large keyboard buttons.

The service used technology to support people and maintain their health and wellbeing. Staff spoke knowledgably about recognising risks people may face when using some traditional equipment such as alarm mats. For example, staff told us they had noticed when the big dark alarm mats had been used to alert staff when people were moving from their bed and bedroom. Due to their diminished sight, some people living with dementia saw the alarm mats as big dark holes in the ground. This meant these people walked around the alarm mats to avoid them which prevented staff knowing when they were moving around. To rectify this the service had implemented the use of bed and chair sensors which activated when people moved and alerted staff so they could support them to mobilise safely.

We received positive feedback from relatives regarding the care and support people received when they were nearing the end of their lives. Relatives told us, "Everyone has been fantastic, so kind and caring and we were so well supported at all times."

The provider had a clear complaints policy and process that explained how people could complain and what people could do if they were not satisfied with the response. We saw guidance on display telling people how they could complain if they had any comments or concerns they wanted to raise. People told us they knew how to complain if they needed to. The service had received two complaints since it opened. These had been followed up and any action taken in accordance with the provider's complaint policy.

The provider had received a number of compliments on their service. Comments included, "To the team at Great Oaks, we just wanted to say a big thank you to you all" and "We appreciate everything you did for [person], thank you for the amazing care you gave to [person]" and "Just a note of thanks and appreciation for all the trouble and help given over the time.'"

Requires Improvement

Is the service well-led?

Our findings

We received differing views regarding whether the service was well led. People told us they thought the service was well led. Relatives told us, "They really keep me informed and I would know who to speak to if I had any concerns" and "The door is always open and there is always someone available to ask if we have any questions." People and relatives said there was a clear management structure in place. However, a health professional gave written feedback and told us the home's atmosphere had gradually worsened over the previous six months. They commented many nursing staff had left and they felt nursing staff received little support with regard to using their clinical skills and judgement.

Staff spoke openly with us during the inspection and told us they very often felt overwhelmed with the amount of work due to a lack of staff. Staff told us they had low morale, felt unsupported and that there was a culture of blame rather than support and encouragement. One member of staff told us, "It doesn't matter if you've done 100 jobs, if you've missed one it's not good enough." They told us if they raised concerns they were not listened to as they could not see any follow up actions afterwards. Staff had raised these concerns to the deputy manager and the registered manager through staff meetings and job chats. Staff raised concerns to inspectors that one manager had discussed their opinions regarding certain staff to the rest of the staff team and had been criticised in front of other staff members, which led to them feeling undervalued.

Staff told us despite the staff shortages they enjoyed their job. They told us they had formed a close working team and enjoyed supporting, nursing and caring for the people who lived at Great Oaks.

Handover meetings were conducted at the start of each shift and team meetings for staff were regularly held. We reviewed minutes from various meetings held within the home. The minutes showed staff had raised concerns regarding the consistent lack of staff and they felt poorly supported and criticised. Minutes acknowledged there had been a large turnover of staff since the service had opened and a more robust induction process had been implemented to support recruitment.

A staff survey had found staff had low morale and felt like they had no support. At a meeting in May heads of department had acknowledged and discussed ways to improve this. For example, 85% of staff job chats were to be completed by the end of May and the 'Value certificates' to be located and used (the value certificate is a scheme used by the provider to celebrate positive good work of employees). However, we found staff had not consistently received their job chat, we did not see any evidence of values certificate being used and staff did not tell us about the values certificate scheme.

The registered manager told us they were aware of how the staff were feeling and had set up a weekly Wednesday morning clinic for any staff to come and raise concerns. They encouraged staff to come and talk openly about their concerns and promoted an open-door policy. The registered manager told us they had recently recruited additional staff and were just waiting for them to start which would ensure the appropriate numbers of staff would be on duty every day and mean less reliance on agency staff. The registered manager also informed us of plans to introduce a new clinical staff role, which would ease the

pressure from the nurses as well as two additional host roles who would support people with food and drink and at meal times. The registered manager said there were plans to involve people in the recruitment of staff. This would mean people would be given the opportunity to take part in the recruitment and interview process which would enable them to put forward their view and feel fully involved in the running of the home and increase their sense of wellbeing.

The service had held a resident and relative meeting since it's opening. People and relatives told us they felt fully involved in their care. One relative told us," All the staff are lovely, I'm told about everything it has all been superb, I know who to contact…I've had no complaints." The registered manager told us about the cheese and wine event that had been run for people and their relatives, which had been enjoyed by all.

Governance systems and audits were in place to monitor quality of work, which included tissue viability, call and alarm bells, care records and medication administration record audits and monthly medication compliance. However, these had not identified the shortfalls we found in medicine management and record keeping during our inspection. The provider had implemented a detailed home development plan, which included concerns and actions to be completed, who would complete the action, when the action would be completed by and each action was given a risk grading. We reviewed this document after the inspection and observed although detailed it did not have any reference of when required actions had been signed off as completed.

Shortfalls in assessing and monitoring the quality of the service was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager understood their responsibilities to provide notifications to the Care Quality Commission (CQC) regarding significant events such as serious injuries and deaths. The registered manager told us they kept updated about changes in practice via email correspondence sent out by the local authority and the Care Quality Commission and attendance at various forums and networking meetings. They had made active links with the local community, had presentations from the local Alzheimer's group and had joined local business forums to ensure the service was visible in the local community. They told us the home had had a stand at a local music festival and actively encouraged visits from the local primary school and nursery, which people really loved and looked forward to. The service ran a very popular fish and chip club on the last Friday of each month that people enjoyed immensely.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Medicines were not always stored, administered or managed safely.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance People's care records were not consistently completed and contained omissions, inaccuracies and some were illegible. The providers governance systems had not identified the shortfalls in medicine management and record keeping that were identified at the inspection.