Prime Life Limited

Charnwood Oaks Nursing Home

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

We carried out an unannounced inspection visit on 21 June 2016 and returned announced on 22 June to complete the inspection.

Charnwood Oaks is a nursing home that provides accommodation for up to 84 people who require nursing or personal care. At the time of our inspection 84 people were using the service. Charnwood Oaks consists of four care units each with accommodation and communal areas. All bedrooms were en-suite.

The service had a registered manager. 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.'

Care staff and non-care staff, for example cleaners, knew how to identify and report concerns about people's safety. Staff were suitably deployed to be able to meet the needs of people using the service. People who were assessed to be at risk of displaying behaviour that challenged others were discretely observed to protect them and other people using the service from harm.

People received their medicines at the right times. The provider had safe arrangements for the management and storage of medicines.

People were supported by staff with the right skills and experience. Staff were supported through training and supervision. A new organisational structure at the service meant that staff had easier direct access to senior staff for support.

Staff at all levels understood the relevance of and acted in accordance with the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards when they supported people.

People were supported with their nutrition. People with special dietary requirements were supported with their specific needs. People were supported to access health services when they needed to. We saw several records that showed the service engaged with a variety of specialist health services to support people with their health needs.

We observed that staff demonstrated care and compassion in the way they supported people. A reason for this was that the provider had improved the quality of the training and support staff received about how to support people in a caring way.

People using the service and their relatives were involved in making decisions about their care and support. People and relatives we spoke with told us they received information they needed about the service before and after they began to use it.

Staff respected people's privacy and dignity. They were discrete when they provided care and support. The provider had taken action to reduce the instances of people's privacy being disturbed by other people walking into their rooms.

People's care plans were focused on their individual needs. People were supported to maintain their independence and were supported to follow their hobbies and interests. An activities coordinator and care staff organised a range of social activities for people to participate in and people were supported with their interests and hobbies. People using the service and their relatives knew how to raise concerns and their views were acted upon.

The service was organised into near four sections each with a team leader and a senior care worker. The `hotel services' manager who managed the kitchen, cleaning and laundry services was an integral part of the management team.

People using the service, their relatives and staff were involved in developing the service. The provider acted upon their feedback. The registered manger and senior staff monitored staff care practice. The provider had effective procedures for monitoring the quality of the service which included seeking people's views about their experience of the service. The registered manager took action to make improvements in areas identified as requiring improvement.

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.

Staff understood how to recognise and report concerns about people's safety.

Staff were effectively deployed. The provider had robust recruitment procedures to ensure as far as possible that only staff suited to work at the service were employed.

People received their medicines at the right time. Medicines were safely managed and stored.

Is the service effective?

Good

The service was effective.

Staff were supported through supervision, coaching and relevant training.

People who did not have mental capacity to make decisions about their care and support had their rights protected because staff understood their responsibilities under the Mental Capacity Act 2005.

Staff supported people with their nutritional needs and with access to health services when they needed them.

Is the service caring?

Good

The service was caring. Staff at all levels supported people with care and compassion.

People using the service or their relatives felt involved in decisions about their care and support.

Staff respected people's privacy and dignity.

Is the service responsive?

Good

The service was responsive.

People received care that was centred on their individual needs.

People had access to a range of activities including activities that supported them to maintain their interests and hobbies.

People and relatives knew how to raise concerns about the service. We saw that the provider had acted upon concerns by meeting with people to resolve their concerns.

Is the service well-led?

Good

The service was well-led.

People using the service, their relatives and staff were involved in developing the service.

The provider had effective arrangements for monitoring the quality of the service which included seeking and acting upon people's views of their experience of the service.

Charnwood Oaks Nursing Home

Detailed findings

Background to this inspection

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

The inspection site visit took place on 21 June 2016 and was unannounced. We returned announced to complete the inspection on 22 June 2016.

The inspection team was made up of an inspector, a specialist advisor who was a qualified nurse and two experts by experience. An expert by experience is a person who has personal experience of using or caring for a person who uses this type of care service. Our experts had experience of caring for older people and people living with dementia.

Before the inspection, we asked the provider to complete 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 spoke with 21 of the 82 people using the service at the time of our inspection, two of their relatives and relatives of three other using the service. We looked at 11 people's care plans and associated records. We spoke with the regional director, the registered manager, clinical nursing lead, a team leader, two senior care worker, three care workers and the `hotel services' manager.. We spoke with two health professionals who visited the service at the time of our site visit.

We looked at two staff recruitment file along with training plans and records associated with the provider's quality assurance system for monitoring and assessing the service.

We spoke with the local authority that funded some of the care of people using the service. We contacted Healthwatch Leicestershire who are the local consumer champion for people using adult social care services to see if they had concerns about the service.

Good

Is the service safe?

Our findings

People using the service told us they felt safe. Most said they felt safe because they were well care for and because there were enough staff to respond to their needs. Two people who used the service said "There are enough staff". Others told us that when they used their call alarms to request support they did not have to wait long for staff to respond. A person told us, "I have used my call bell on a few occasions for drinks and things. They [staff] get me what I want and I haven't had to wait". Another person told us, "I use it [call alarm] and sometimes if it's busy I will wait a little but they can't help that". They and other people we spoke with told us they had not experienced discomfort from having to wait an undue period of time for staff to support them. Our observations were that staff responded to call alarms within 20 seconds.

A relative told us, "I can leave here knowing [person's name] is safe". They and other relatives told us they felt enough staff were deployed. We saw staff in communal lounges where most people spent their time. Staff told us they were there to support people but also to make discrete observations to see whether people needed support or to observe people who at times displayed behaviour that challenged others. They did this so they could make timely interventions to protect people. A person using the service told us, "There are always staff around to look after me, so I don't have to worry". A relative of another person told us, "I never worry about leaving [person using service] when I go after visiting. The staff are always looking in on him".

Staffing levels at the service were determined by the registered manager in consultation with team leaders. They used a method that took into account people's needs and the level of support they required. They also ensured that when staff rotas were planned, there were enough staff with the right skills and knowledge to be able to meet the needs of people using the service. For example, in a section where there was a higher concentration of people with behavioural need, team leaders ensured that enough staff with training and skills in supporting people with behaviour that challenged were on duty. People using the service and relatives we spoke with told us they felt enough staff were deployed. Another indicator that staff were effectively deployed was that staff responded quickly to requests for support and we saw staff spending time talking with people. A care worker told us, "There are enough staff. It's made such a good difference having team leaders because they make sure there are enough staff in the team".

When we saw staff support people with transfers using a hoist they did so safely. We heard staff explain to people how they were going to be supported and they helped people to feel relaxed. For example, when transferring a person using a hoist a care worker joked "You are going up to the moon again" to which the person laughed. A person who used the staff told us, "They staff are very good at using it [a hoist]". Some people required walking frames to assist them with their mobility. We saw a person get up from their chair and take a few steps without their walking frame. A care worker quickly intervened and stood beside the person talking with them whilst another brought the walking frame which had been beside the chair where the person had been seated. The care worker gently reminded the person, "Never walk anywhere without your frame" then observed the person walk to where they wanted using the frame. Care workers therefore protected people from the risk of falls and avoidable harm.

Staff also supported people when they walked along corridors. Care records we looked at showed that several people liked to `walk around' the service. The staff understood that this posed a risk that people may go uninvited into other people's rooms and that the occupants of those rooms did not always like that. A person told us, "I have had problems in the past with people coming into my room but I told them about it and now I have my special (stable) door, so it's stopped". Staff did not prevent people from walking along corridors which was correct because to have done so would have deprived people of freedom to move around the service. We saw staff observe from a distance of 10 metres when they walked along corridors past people's rooms. When it looked as if a person was going to enter another person's room, staff intervened, spoke to the person and explained why they shouldn't go into another person's room. Staff therefore protected people from potentially confrontational situations.

People's care plans included risk assessments associated with people's care routines. This meant care workers had access to information about how to support people safely. Where appropriate care plans also contained information about people's behaviour and possible triggers to behaviour that challenged others. This meant that care workers had information about how to protect people from harming themselves and others by recognising signs a person was anxious. We saw care workers anticipate risks and make timely interventions.

Staff we spoke with, which included care workers and cleaners, knew how to recognise signs of abuse. They were attentive to signs of unexplained bruising, changes in mood or behaviour and eating habits. They knew about the provider's procedures for reporting abuse either to a colleague or a senior. They were confident their concerns would be taken seriously. They were also aware of the provider's whistleblowing procedures which encouraged staff to report safeguarding concerns anonymously using a whistle blowing call-line. We saw posters about whistleblowing displayed in corridors. They were supported to retain their knowledge of these procedures by their team leaders.

The provider had procedures for reporting and investigating accidents and incidents. The registered manager cooperated with the local authority safeguarding team when they carried out investigations at the service. That cooperation extended to working with the local authority to achieve improvements in safety of people using the service.

The provider had arrangements for the maintenance of equipment and monitoring the safety of the premises. Equipment such as hoists and stand-aids was serviced and maintained. The registered manager had taken steps to protect people from harm and injury by ensuring that store rooms where cleaning equipment and chemicals were stored were locked. At our last inspection we found that two store rooms that should have been locked were not locked and that fire doors were left open. At this inspection every store room and restricted area was locked whenever we tried a door.

Recruitment files showed that the provider had effective recruitment procedures. These included assessment interviews for people who were selected for interview after submitting an application to work at the service. All the necessary pre-employment checks were carried out before a person joined the service. These included Disclosure and Barring Service (DBS) checks. These checks help to keep those people who are known to pose a risk to people using CQC registered services out of the workforce. People using the service could be assured as far as possible that only people suited to work at the service were employed.

People using the service were supported to have their medicines at the right times. A person told us their "medicines are fine". Whilst we were talking with them, they told a care worker they were uncomfortable with pain. The care worker immediately asked if they needed any paracetamol, as well as discussing the strength that they thought they would need. This gave the person choice and control over pain relief. A

relative of another person told us how staff arranged for people's medicines to be reviewed by a GP after their parent hadn't always taken their medicines. They told us, "Person's name] didn't always take the medicine. They home arranged to change the medicines into liquids or dissolvable to make it easier". The relative was pleased about that because their parent was more receptive to taking their medication.

The provider's medications management policy was based on the latest guidance about medicines management. Medicines were stored safely and there were effective arrangements for the disposal of medicines that were no longer required. Only staff who were trained to give people their medicines did so and their competencies to continue to do so were regularly assessed.

Good

Is the service effective?

Our findings

People using the service told us they felt well looked after by staff who they felt were well trained and knowledgeable about their needs. A person using the service told us, "The staff are very nice. They all talk to me and get to know me". Other people told us, "They [staff] know me well" and, "The staff know what they are doing" and "They couldn't be better, I am always being looked after". A relative of a person using the service told us, "Staff have gone out of their way to try and get to know [person using the service]".

The registered manager and the team leader we spoke with displayed in-depth knowledge about needs of people using the service. They passed on and shared this knowledge with care staff at meetings. Team leaders supported care workers by coaching them on how to support people with their needs. Care workers we spoke with displayed good knowledge of the contents of people's care plans. They told us, for example, about what people liked and disliked and about people's care routines. They told us they developed their knowledge of people's needs by reading their care plans and from the support they received from their seniors and team leaders. They also told us they spent time talking with people who used the service to get to know them.

We saw and heard several instances of staff engaging in conversation with people about how they wanted to be supported and then doing what people asked. This showed that staff communicated effectively with people. A noticeable improvement from our previous inspection was that care staff displayed tact and skill when people presented behaviour that challenged. Staff diffused situations by anticipating behaviour, distracting people from what troubled them by engaging in conversation and offering an activity, for example going for a walk into the garden. This was partly the result of the provider having sought out an external training provider to deliver training for staff on how to support people in challenging situations. A care worker told us, "The training was really good. I know now how to identify when a person might be displaying signs of challenging behaviour and I can respond to support them". Team leaders supported staff to put their training into practice. A care worker told us, "The training with Primelife has been brilliant". Another told us, The training I had about dementia changed my perceptions about the impact dementia has on people's lives". Care workers told us that they felt supported by their team leaders and senior care workers to put their training into practice. One told us, "We get a lot of support".

After our last inspection the provider introduced a `clinical excellence programme' to support nurses employed by the service to develop further skills and knowledge outside their area of expertise. Under this programme they were also taught about supporting people with mental health issues. We saw from records we looked at that nurses at the service engaged with specialist NHS mental health services to ensure that people accessed those serviced when they needed them.

Staff were supported by their line managers through regular meetings, called `supervision meetings', where their performance and training needs were discussed. The new management structure at the service meant that staff had regular supervisions with their direct line manager. A care worker told us, "My supervision meetings make me feel I'm well supported. My supervision listens. It's been an excellent thing to have supervisions". Staff were encouraged to study for additional qualifications using the provider's staff

development programme.

All staff we spoke with understood the requirements of the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS). MCA and DoLS is legislation that protects people who lack mental capacity to make decisions about their care and who are or may become deprived of their liberty through the use of restraint, restriction of movement and control. Any restrictions must be authorised by a local authority. Where people were under a DoLS authorisation the staff complied with the conditions. The provider had effective procedures for ensuring that authorisations were reviewed before they expired which meant that no people were under any restrictions without them being properly authorised. The registered manager, team leaders and nurses had a practical working knowledge of the MCA. Senior care workers and care workers showed an awareness of it and knew why people at the service were under a DoLS authorisation. That knowledge and awareness was achieved because the provider had developed their own `MCA key principles' cards which explained in simple language how the MCA was relevant to their roles. Just before our inspection, the provider introduced procedures for checking staff understanding and practice of MCA at regular intervals.

We saw that staff sought people's consent before they provided care and support. A person who used the service told us, "They don't force you to anything". A relative told us, "They [staff] always ask [person using service before they do anything and let him know what they are going to do". We heard and saw staff using language and gestures to ask people if they wanted support and only proceeded to provide it after the person consented. This showed that staff understood they could provide care and support only if a person consented to it. People who lacked mental capacity to consent to care had decisions made in their best interests under DoLS.

People using the service told us they enjoyed the meals at Charnwood Oaks. Comments from people included, "The food is lovely", "its nice food, especially nice dinners" and "the food is good, it's what I like". People had a choice of food and drinks. We saw and heard care workers asking people what they'd like for lunch. A person told us, "The food is good as I have a choice" and another person told us, "The staff just know what I like and only bring me those things." People's care plans included information about their dietary needs and preferences. This information was known to staff in the kitchen where food was prepared. People with special requirements, for example food in pureed form or fortified drinks received the support they required. A relative told us, "Mum has been prescribed protein drinks by the GP recently and they just seem to appear throughout the day. Mum loves them. She has been eating much better since being here". Another relative told us, "My father is definitely happy with the quality of the food here". People were provided with fresh drinks and snacks throughout the day. A person told us, "The food is very good and there is enough of it. I have certainly never gone hungry". We saw people being offered drinks, snacks, fruit and chocolate by care workers.

The provider had procedures in place for staff to monitor people's nutritional health. This included regularly weighing people and acting on any unplanned weight loss, for example by arranging for peoples doctors and dieticians to be involved in their care. We saw evidence that this had happened. Care workers maintained records of the amounts of food and fluid that people consumed drink. Team leaders and nurses were advised if people were eating or drinking less than the recommended levels and they took action when necessary, for example advising the person's GP so that a referral to a dietician could be considered.

We observed meal times in all four dining areas. People who required support with eating their meals received it. Staff were effectively deployed throughout the mealtime period which meant people did not wait an undue time for their meals. Several people had their meals in their rooms and we saw staff support people who were in their beds to eat their meals.

Relatives we spoke with told us that they felt their loved one's health needs were met. A relative told us, "I'm very pleased with the health care my father receives. The nurses and staff keep me informed about his health. We saw evidence in care plans we looked at that people were supported to access health services, for example dieticians, dentist and specialist mental health services. The service worked closely with a GP from a local medical practice who visited the service every week to review people's health. They told us, "The quality of care here is perfect. The staff are very good at picking up on people's weight loss. The staff make appropriate referrals to me and they act on my instructions". We saw evidence that the registered manager had been persistent in supporting a person to have an operation which had transformed the quality of their life. They liaised with the right people to identify when the operation was most likely to benefit from the operation. We spoke with that person who told us about how much better they felt as a result of the operation. This showed that the service cooperated with health services to make a difference to the quality of people's lives.

Good

Is the service caring?

Our findings

People using the service told us that staff were kind and caring. A person told us, "They staff are caring but not over the top which is how I like it". Another person told us, "The staff are lovely. They care about me and I love it here because of that". Another person told us, "The staff here are lovely. They are like my family. In fact they are more patient than my family". Relatives we spoke with told us they felt the service was caring. One told us the caring nature of the service showed itself in various ways. They told us, "My father gets the care he needs, the staff are very caring. I've never seen anything that has concerned me. I visit often and come at different times. I'd know if the staff weren't caring".

The provider promoted dignity in care through staff training and supervision. The provider had introduced a new `tool kit' for registered manager and team leaders to monitor whether staff put their training about treating people with dignity into practice. This was called `sit & see' and was a means helping an observer to identify examples of compassionate care and to review and share their findings with staff who had been observed. The intention was to consolidate and build upon the skills taught in training through practical support. We saw staff talk respectfully with people. They referred to people by their preferred name when they spoke with them or about them to other staff.

The provider had procedures for finding out what was important to people and for staff to act on the information. Care plans we looked at had a section called `getting to know you' which was intended to support staff to understand what mattered to people so that they could provide care and support that met people's needs. Care workers we spoke with demonstrated they knew what was important to people and what they liked. For example, they knew how people liked their drinks and food, how they liked to spend their time and what caused people anxiety. They used their knowledge to support people to feel comfortable and safe. A relative told us, "I can see that the staff are caring. They like my mum and know about her". Another relative told us, "The staff are caring". They told us about little things staff did that made people happy. For example, a care worker regularly brought their dog to Charnwood Oaks because they knew people liked it. A relative told us, "My father smiles when he sees the dog".

We saw examples of staff being kind and compassionate. We saw staff providing people with reassurance when they displayed signs of anxiety. Staff held people by the hand when they talked with them to show they cared. They helped people feel they mattered by supporting them to do things that were important to them and praising their efforts. For example, a person attempted to play a tune on a keyboard. When it appeared the person was frustrated that they were making mistakes a care worker encouraged them and suggested to the person "sing the tune in your head first, you can do it". The person tried a couple more times before playing the tune to completion. When they had finished, every person in the room joined in a round of applause. When we spoke with this person later they expressed a sense of achievement about what they did earlier.

We saw staff tried to help people feel they mattered and they developed caring relationships with people. A person told us, "The girls [staff] can be nice, I think it's okay, I treat them like a daughter". Another person told us, "They speak to me and ask me what I like. They let me do what I want". We saw and heard care

workers having meaningful and stimulating conversations about what they were reading, the weather, what they were going to have for lunch and their family. We also saw and heard cleaning staff speak with people when they were cleaning people's rooms. People joined in the conversations. When we spoke with cleaning staff they told us they enjoyed talking with people when they were in their rooms.

Relatives we spoke with told us they felt involved in decisions about their loved one's care. One told us, "I'm asked for my opinion and I feel I'm listened to". They explained they'd told staff about radio and television programmes their mother liked and that staff put those programmes on for the person to listen to and watch. Another relative told us, "I am involved. I'm asked for my views and I attend relatives meetings. If I have any questions they are always answered". Relatives were involved in providing information. One told us, "They even sat with me one day just after she came in and had me identify family members from photos so that they would know them when they came to visit". Relatives told us they felt that being kept informed about their loved one's was important and that the service did that well. A relative told us, "After my father had a fall, staff called straightaway and explained what happened".

Care staff acted quickly to relieve people's distress or discomfort. When a person showed signs of anxiety because a relative had not visited them, a care worker gave reassurance by talking about the relative. When care worker's noticed that a person had slumped in their chair whilst asleep they gently woke them and repositioned them into a comfortable position. A person told us how care workers lifted their mood at times they felt unhappy. They told us, "Some days I can't be bothered but the carers cheer me up and then I'm okay." When we saw a person decline food because they thought they had to pay for it, a care worker explained it was all paid for and that she didn't have to worry about anything. They repeated this several times and in several different ways until the person understood and began eating their food. The care knew how to respond because this was a known behaviour by the person. Another care worker noticed that a person had scratched themselves and was bleeding. They immediately attended to the wound, applied a wet tissue to press onto the wound before applying some cream.

Care workers respected people's daily choices about their personal care routines and how they wanted to spend their time. A person told us that they chose whether they had a bath or a shower and that staff respected their choice. The person told us it mattered to them that they had a choice. Another person told us, "They [staff] let me do what I want". Care workers respected people's choices about how they spent their time including when this may have inconvenienced others. A relative told us of an occasion when there had been a visit to a garden centre. They told us, "It was a nice day. Well apart from one resident who refused to budge from a seat in the garden centre for two hours." However, this showed that staff respected people's individual choices.

Staff respected people's privacy and dignity. A person using the service told us, "I can't fault it here. The carers are all lovely and treat us with respect". We observed staff knock doors before entering people's rooms. Signs were used to indicate that people were receiving personal care requesting that people did not enter the rooms at those times. A person told us, "I stay in my room out of choice, I am a quiet person. I have privacy in my room as I am that sort of person". We saw care workers adjust people's clothing or cover people to protect their modesty. When care workers supported people with their personal care in their rooms they ensured people's privacy. We heard a care worker tell a person as they helped them to their room, "Let me just close the bedroom door before we sort your clothes out".

Relatives were able to visit without undue restrictions. Entries in the visitor's signing-in book showed that relatives visited throughout the day, from early morning to late evening.

Good

Is the service responsive?

Our findings

We saw in care plans we looked at that people using the service who were able to, contributed to the assessment of their needs and planning of care. Care plans included information about people's needs and guidance for care workers and nurses about how they wanted to be cared for and supported. A person using the service told us, "I love it here. They do everything for me".

Staff supported people to contribute to the planning and delivery of their care. They did this by offering choices or asking people what they wanted. People's choices were respected. A person told us, "We are allowed to get up when we want". Another person told us, "There is lots of choice on things". The choices were about things like whether they preferred a bath to a shower, or when they wanted to be supported with an activity or where they spent their time. Staff supported people who changed their mind. For example, a person told staff they wanted to spend time in their room but after we'd spoken with them about how nice the weather was they asked a care worker to take them into the garden and a care worker did so immediately. A person told us, "If I want anything, I just need to ask and if it needs doing, it gets done". Another person told us that staff were flexible about how they provided care and support. They told us, "They (staff) are willing to help and try different things". This showed that staff sought to provide care in line with people's wishes and preferences rather than in a task orientated fashion.

People were satisfied with the quality of care they experienced. A person told us, "The life I live now is the best I could ever have". Another person told us, "There is nowhere better, I really like it here". Relatives of people using the service told us they felt that their spouses or parents received care that was centred on their needs. A relative told us, "[Person using service] gets the care they need. The staff are understanding of [person's] needs". Another relative told us how a person's quality of life had improved since they came to Charnwood Oaks Nursing Home. They told us, "The family chose to move mum here from another care home. Her room is much bigger and very light which is nicer for her. We have no worries and she is eating much better now".

People's care plans included information about how they should be supported with their needs, for example with personal care and how their health should be monitored. Care records we looked at showed that people's health was regularly monitored and that changes to care plans were made to reflect changes in people's circumstances, for example changes to people's medication or increased risk of falls. Care plans were reviewed monthly by senior care workers and team leaders in consultation with nurses if people required nursing care.

When people's needs were assessed and reviewed at regular intervals, they and their relatives were asked about what people's hobbies and interests were. Details were recorded in a `getting to know you' sections of people's care plans. Care workers we spoke with knew about people's interests and they supported people to follow them. This operated at different levels. Care workers reminded people when their favourite television or radio programmes were being broadcast and supported people to watch or listen to them. Other people liked reading particular newspapers or magazines; others liked to spend time in the garden, watch wild-life from their rooms or go for walks. They were able to enjoy those pursuits with staff support.

Since our last inspection corridors were decorated with sensory and tactile objects that provided people with points of interest when they walked along corridors. Other people had practical interests like drawing and painting or playing musical instruments. The activities co-ordinator and registered manager were considering how to develop a care worker's suggestion that people may enjoy a music club or the possibility of a `resident's orchestra'. We saw people reading, watching television, listening to the radio, completing adult colouring books and walking in the garden and inside the home. A person told us they liked making models and we saw models they had made. People were supported to perform meaningful tasks. For example, we saw a person who liked to walk along corridors to inspect the cleanliness of those areas. A care worker gave the person a dust cloth which they evidently enjoyed using.

People were able to participate in social activities. For example the Queen's 90th birthday celebrations, garden fetes and day trips to places of interest selected by people using the service. like birthday parties. A relative told us about the Queen's birthday celebration. They said, "It was a fabulous day. The buffet was amazing and when the entertainment came on later, all the residents were out there dancing or at least trying to dance. You wouldn't have thought some of them could even get up from their chairs before I saw that. I was amazed". A `sports lounge' was used for quizzes and games. People of faith were supported to attend on-site faith service. People were also supported with one-to-one activities. A relative told us, "There is always something going on".

People had information available to them about how to make complaints. Relatives we spoke with told us they knew how to make complaints or raise concerns. Relatives who had raised concerns told us that they had been listened to and that their concerns had been acted upon. A relative told us, "When I've raised a comment about something it is resolved well and I am happy with the outcome". When people made complaints these were investigated by the registered manager who, after the investigation, met with people to explain their findings and actions they had taken. A person using the service told us they had raised a concern about the behaviour of some of the people using the service. They told us, "They did understand what I was saying and tried to change it".

The provider had procedures for staff to report concerns about delivery of care or incidents and accidents. Staff we spoke with were familiar with those procedures. Reports were investigated by team leaders, nurses and senior management. Care workers we spoke with told us they had feedback about the outcome of investigations. They told us this made them confident about raising concerns if they had any.

Good

Is the service well-led?

Our findings

People using the service did not tell us directly that they felt involved in developing the service. However, they felt involved in decisions about the delivery of care and said that their suggestions and requests had been acted upon. For example, people who attended `residents meetings' told us they made suggestions about activities, social events and outings which were acted on by the service.

People using the service knew who the registered manager was. A person told us, "I see her walking around during the day. She seems nice and always says hello". People did not always know the names of the manager, team leader or nurses but they were able to distinguish what roles people had because of the uniforms they wore.

Staff were supported to raise concerns they had about poor practice. They knew they could raise concerns through procedures that were in place for doing so. These included a whistle blowing procedure through which staff could raise concerns anonymously with senior people in the provider organisation. Staff knew they could raise concerns with their line managers at any time and at formal supervision meetings which included concerns as an agenda item.

The registered manager, a clinical lead (a nurse), team leaders and the regional director (when they visited the service) `walked the floor' to observe care practice and monitor how staff supported and behaved towards people using the service. They did this to monitor whether staff put their training into practice and practised the values and behaviours expected of them in the provider's code of conduct.

The team leaders, clinical lead and hotel service's manager all told us they felt part of the management team at Charnwood Oaks. They worked together for the benefit of people using the service. For example, team leaders and the clinical lead contributed their specialist skills and knowledge to reviews of people's care plans and the hotel services manager ensured their staff provided practical support such as ensuring people had the right foods and drinks prepared and their clothes returned to them after being in the laundry.

The service was organised into four sections each with a team leader reporting to the registered manager. Staff we spoke with understood the organisation of the service and people's roles in it. They told us the way the service was organised made lines of accountability very clear and they felt well supported. One told us, "The new structure has brought definite improvement and we have a strong and stable management team". A team leader welcomed the new structure. They told us, "It's so much better. I feel I can lead my team and work `hands-on' with the care workers in my team. I can also spend quality time with people using the service". We saw team leaders and senior care workers spending time talking with people and this gave a good example to care workers who told us they were encouraged to do likewise. Care workers told us they liked the new structure at the service. One told us, "It's good that we work in assigned units because we get to know the people and that is good for them. We work well together in our team and the teams support each other". A relative told us, "The staff seem happy on the whole here. It is much better now than it was last year. There were all sorts of problems. I think they have been managed-out now though as it is a lot

better".

The registered manager was aware of their responsibilities to inform the Care Quality Commission (CQC) us and the local authority that paid for the care of some of the people using the service of events at the service. These included unexpected deaths, serious injuries and incidents between people using the service. The quality of reports to the CQC was good and meant we were kept informed about how the service addressed concern and protected people.

The management team had a shared understanding of the challenges facing the service and had action plans to address those challenges. They were supported by the regional director who was a member of the provider's operational board. Board members supported the registered manager to raise the standards through the provision of better quality training that was targeted at improving staff skills. For example, new training helped staff develop a more in-depth knowledge about the impact of dementia and supporting people at times they displayed behaviour that challenged others. This was a notable improvement from what we found at our last inspection and showed that the provider strove for continuous improvement.

Staff knew what was expected of them because they had regular supervision meetings, training and newsletters to keep them informed about the service and its aims. Staff we spoke with knew what the provider's mission statement was – which was for people to `enjoy life at Primelife care homes'.

The provider had quality assurance procedures that operated at two levels. At service level, the registered manager and clinical lead and team leaders carried out regular scheduled checks about the quality of care provided. These were reported to the regional director who carried out their own checks, some of which were to verify what had been reported to them. We found the quality assurance procedures to be geared towards identifying areas that required improvement. Findings from internal investigations and from safeguarding investigations carried out by the local authority were used to identify and implement improvements. The registered manager was supported with their quality assurance responsibilities by a `quality matters toolkit' that had been developed by the provider and supplied to all registered managers. The tool kit included CQC's guidance for providers and guidance about how to carry out audits.

A key part of the quality assurance was a survey that sought people's and relatives views of their experience of the service. The most recent survey results were that nearly all people responding to the survey rated the service as either outstanding or good in terms of safety, homeliness and, being caring.