Four Seasons 2000 Limited

The Oaks Care 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?	**Outstanding**
Is the service responsive?	**Good**
Is the service well-led?	**Requires improvement**

Overall summary

The inspection took place on 15 April 2015 and was unannounced. We carried out a second visit to the home announced on 17 April 2015 to complete the inspection.

We last inspected the service in July 2014, where we found a in breach of one regulation which related to the management of medicines. We carried out a review in September 2014 and found that the improvements had been made and the provider was now meeting this regulation.

The Oaks Care Home accommodates up to 45 older people, most of whom have dementia related conditions. There were 20 people living at the home at the time of the inspection.

There was a manager in post. She was in the process of applying to be a registered manager. She had completed her "fit person's interview" with a Care Quality Commission (CQC) registration inspector. A registered manager is a person who has registered with the CQC to manage the service. Like registered providers, they are

Summary of findings

'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.

There were safeguarding procedures in place. Staff knew what action to take if abuse was suspected. We spoke with the local authority safeguarding officer who told us that there were no organisational safeguarding concerns regarding the service.

We spent time looking around the premises and saw that the building was generally clean and well maintained. There were no offensive odours in any of the areas we checked. We found the design and decoration of the premises met the needs of people who had a dementia related condition.

We checked medicines management. We noted that medicines administration records were completed accurately. The manager was in the process of identifying a more suitable room for the storage of medicines.

Staff told us that training courses were available in safe working practices and to meet the specific needs of people who lived at the home. For example, dementia care training to further support people with this condition.

CQC monitors the operation of the Deprivation of Liberty Safeguards (DoLS). DoLS are part of the Mental Capacity Act 2005 (MCA). These safeguards aim to make sure that people are looked after in a way that does not inappropriately restrict their freedom. We found that the service had made a number of applications to the local authority to deprive people of their liberty in line with legislation and case law. There was evidence that "decision specific" mental capacity assessments had been completed and best interests decisions made.

People and relatives were complimentary about the meals at the home. We observed that staff supported people with their dietary requirements. Staff who worked at the home were knowledgeable about people's needs. We observed positive interactions between people and staff. Staff communicated well with people.

Relatives with whom we spoke on the days of the inspection, were happy with the service. One relative said, "It's in between good and outstanding - a B plus I would say." Other comments included, "I'm happy with my choice" and "Nobody wants their parents in a home, but you want them cared for and I find in here I can trust them to look after her. They follow my instructions. I have no complaints."

There was an activities coordinator employed to help meet the social needs of people who lived there. An activities programme was in place.

The manager explained that the service had been through a period of significant challenge since she had taken up the post of manager in September 2014. Occupancy levels had fallen following a number of expected deaths. Most staff informed us that more support from the manager would be appreciated and commented that morale was sometimes low.

A number of checks were carried out by the manager. These included checks on health and safety; care plans; the dining experience; infection control and medicines. Action was taken when concerns were highlighted during these checks. It was sometimes difficult however, to ascertain what actions had been taken in response to checks and tests of the premises. This was due to the provider using an external maintenance company who did not update the computerised system when remedial work had been carried out.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was safe.

There were safeguarding procedures in place. Staff knew what action to take if abuse was suspected.

The building was generally clean and well maintained. There were no offensive odours in any of the areas we checked.

Staffing levels had been reduced because of low occupancy levels. We received mixed comments from staff about whether there were sufficient staff on duty to look after people. We observed that staff carried out their duties in a calm unhurried manner on both days of our inspection. Safe recruitment procedures were followed.

Good

Is the service effective?
The service was effective.

Staff told us that training courses were available in safe working practices and to meet the specific needs of people who lived there, such as dementia care training

Records demonstrated that care and treatment was delivered in line with the Mental Capacity Act 2005. We found the design and decoration of the premises met the needs of people who lived with dementia.

People and relatives were complimentary about meals at the home. The cook was knowledgeable about people's dietary needs and we saw the kitchen was well stocked with ingredients such as milk, cheese, cream and eggs with which to fortify meals.

Good

Is the service caring?
The service was caring.

People and relatives told us that staff were exceptionally caring. We saw positive interactions between people and staff. Staff spent time talking with people on a one to one basis.

Relatives told us and our own observations confirmed, that staff promoted people's privacy and dignity. We saw that staff knocked on people's doors and spoke with people in a respectful manner.

Outstanding

Is the service responsive?
The service was responsive.

Relatives told us that staff were responsive to people's needs.

Good

Summary of findings

There was an activities coordinator employed to meet the social needs of people who lived there. An activities programme was in place.

There was a complaints procedure in place. Feedback systems were used to obtain people's views. For example, "Residents and relatives" meetings were held and surveys were carried out.

Is the service well-led?

Requires improvement

Not all aspects of the service were well led.

The manager was in the process of applying to be a registered manager. She explained that the service had been through a period of significant challenge since she had taken up the post of manager in September 2014.

Most staff informed us that more support from the manager would be appreciated and commented that morale was sometimes low.

A number of checks were carried out by the manager. These included checks on health and safety; care plans; the dining experience; infection control and medicines.

The Oaks Care 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 team consisted of an inspector; a specialist advisor in governance; a CQC senior analyst and an expert by experience, who had experience of older people and care homes. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of service.

The inspection took place on 15 April 2015 and was unannounced. We carried out a second visit to the home announced on 17 April 2015 to complete the inspection.

We spoke with six people and seven relatives. We conferred with a community matron for nursing homes; a GP; two social workers; a challenging behaviour clinician from the local mental health trust; a community psychiatric nurse and a continence advisor from the local NHS trust. We also spoke with a local authority safeguarding officer and a local authority contracts officer.

We spoke with the regional manager; manager; deputy manager; two nurses; an activities coordinator; five day care workers and five night care workers; housekeeper; maintenance man, cook and kitchen assistant. We read three people's care records and five staff files to check details of staff training. We looked at a variety of records which related to the management of the service such as audits, minutes of meetings and surveys. We also checked an online independent care homes guide. This website included details of recommendations from both the public and people who lived at the care homes. All three comments we viewed were posted in March 2015 by relatives.

Prior to carrying out the inspection, we reviewed all the information we held about the home. The provider completed a provider information return (PIR). A PIR is a form which asks the provider to give some key information about their service; how it is addressing the five questions and what improvements they plan to make.

Good

Is the service safe?

Our findings

None of the relatives whom we spoke with on the days of our inspection raised any concerns about people's safety. One relative said, "I come every day and have never seen anything amiss." Another stated, "There's no weak links here. I've never seen any of the carers getting frustrated or cross. They are so patient." A GP told us, "It's good; it's as safe as it can be...There's very few falls."

There were safeguarding policies and procedures in place. We spoke with staff who were knowledgeable about what action they would take if abuse were suspected. One care worker said, "Most of us have been here a long time; we would not tolerate anything iffy from anyone" and "We all know how to report stuff." We spoke with the local authority safeguarding officer who told us that there were no organisational safeguarding concerns regarding the service.

Risk assessments were in place which covered a range of areas such as moving and handling, skin integrity, malnutrition and falls. Staff were knowledgeable about the actions to take to prevent and reduce any identified risks.

We spent time looking around the premises. We saw that the building was generally clean and well maintained. We noticed that some of the window frames were in need of redecoration. The maintenance man told us that this had already been highlighted and was going to be addressed. Many people who lived at the service required assistance with continence care. We found that there were no strong offensive odours in any of the communal areas or people's bedrooms. This was confirmed by the continence advisor with whom we spoke. He said, "There's not an issue with odours here." We looked at an independent care homes website. One relative had commented, "The place is clean and they keep the residents clean, changing them when necessary. I would definitely recommend this care home to anyone."

A number of checks and tests were carried out to ensure the safety of the premises. We spoke with the manager about how maintenance issues were managed. She told us that they used an external maintenance contractor to carry out the maintenance and servicing of the premises. She said a computer portal was used to record planned and requested maintenance work.

We read the minutes from the latest health and safety meeting which was held on 26 March 2015. The manager had highlighted concerns regarding the safety of the electrical installations of the home. She told us that because the external contractor did not update the computer portal when remedial work had been carried out; it was difficult to ascertain whether the concerns highlighted in some of the checks and tests had been addressed. During the inspection, the manager provided us with an electrical compliance record stating the required remedial work had in fact been carried out.

We checked the equipment at the home which included moving and handling hoists; scales; bed rails and wheelchairs. Regular tests were carried out to ensure all equipment was safe. We read the minutes from the latest staff meeting on 23 March 2015. This stated that there had been an issue with weighing people who were unable to mobilise. As a result, new specialised scales had been purchased.

We checked staffing levels at the service. There had been a reduction in staffing numbers because of the reduced occupancy in the home. No permanent staff were based upstairs through the day. Most of the nine people who lived upstairs came downstairs to socialise and access the communal areas with the exception of one person who was looked after in bed.

Prior to our inspection, we received two separate concerns about staffing levels. We passed these onto the local authority's safeguarding team who carried out an unannounced visit. The local authority sent us a copy of their report which detailed several recommendations. We read that the safeguarding officer had written, "There should be a staff presence on the top floor or a more robust system to manage the people upstairs and ensure they are not at risk."

We saw that the manager had instigated a system to monitor the person who was looked after in bed on the first floor. Half hourly documented checks were in place to check they were safe and comfortable. The regional manager stated, "On top of the 30 minute checks, this resident has extended one to one support during periods of hydration, nutrition and personal care. They also receive regular one to one social intervention visits from [name of activities coordinator]. Staff ensure that during periods of alone time that the resident has their music playing softly

Good

Is the service safe?

or TV switched on for sound awareness stimulation and comfort." We visited the person who was looked after in bed and saw that they looked well-presented and comfortable. Quiet music was playing in the background.

Day staff informed us that while they were busy; they felt there were sufficient staff on duty. They said they would benefit from additional staffing to enable them to enhance the quality of care they were providing. They recognised however, that the under occupancy did have an impact on the staffing resources which were available. Most of the night staff said that more staff would be appreciated. They explained that staffing levels had been reduced to one nurse and two care workers. They said it was particularly busy when they were supporting people to go to bed.

We spoke with the manager and regional manager about the comments made by night staff. They provided us with information that between September 2014 to the date of the inspection, there had been no recorded incidents or accidents between 8pm until midnight. Night staff confirmed that there were very few accidents or incidents on night duty because they were very vigilant.

The duty rotas for the four weeks preceding the inspection were examined. These reflected the staffing levels described by the manager. We saw that bank and agency staff were used to cover a number of nursing shifts. The provider had their own bank staff and the manager told us that she always requested the same bank or external agency staff to ensure continuity of care. The staff rotas confirmed this.

During both visits to the home; we observed that people's needs were met and care and support was carried out in a calm unhurried manner. We therefore concluded that there were sufficient staff on duty to look after people.

We checked medicines management. We spoke with a GP who said, "They don't use sedative drugs except very small doses if absolutely necessary." This was confirmed by the medicines administration records we checked.

Medicines were stored in a small room which adjoined one of the ground floor lounges. The manager recognised that this was not ideal because the area was busy and nursing staff could be easily interrupted when they were dealing with medicines. She told us they were in the process identifying a more suitable room for the storage of medicines. We checked everyone's medicines administration records and saw that these were completed accurately. There was a system in place for the receipt and disposal of medicines.

Staff told us that the correct recruitment procedures were carried out before they started work. One staff member said, "I got a phone call to say my CRB was clear, I could then start." We checked one staff member's recruitment records who had recently started. We saw that a Disclosure and Barring Service check had been obtained. This was previously known as a Criminal Records Bureau check (CRB). In addition, two written references had been received. There was a system in place to check that nursing staff were registered with the Nursing and Midwifery Council [NMC]. The NMC registers all nurses and midwives to make sure they are properly qualified and competent to work in the UK.

The manager demonstrated strong governance when dealing with disciplinary matters. She had investigated concerns about one staff member's conduct and clinical skills. This had resulted in their dismissal and referral to the appropriate authorities including the NMC. Records were available to demonstrate all actions taken.

Good

Is the service effective?

Our findings

Relatives told us that they considered that staff were trained and knew how to look after their family members. One relative said, "Yes, I think they know what they're doing." Other comments included, "They are on the ball," "They engage with her well" and "The nurses are very thorough. I know this as I have medical knowledge."

Staff told us that there was training available. One staff member said, "We have plenty of updates, we do the e-learning thing as well." The manager provided us with details of staff training which evidenced that the majority of staff had achieved 100% compliance in training which the provider had deemed "mandatory." This included training in safe working practices such as moving and handling. Training had also been carried out to meet the specific needs of people who lived at the home such as dementia care training.

We spoke with a community matron for nursing homes. She told us that she had delivered clinical training to the staff including venepuncture [taking of blood], verification of expected death and training on the use of syringe drivers [a small pump which releases a dose of painkilling medicine at a constant rate].

The manager provided evidence that staff received regular supervision. The regional manager provided her own supervision and support for the manager. All staff confirmed they received supervision individually. One member of staff explained group supervision occasionally took place to address specific topic related issues. Annual appraisals were carried out. Supervision and appraisals are used to review staff performance and identify any training or support requirements.

CQC monitors the operation of the Deprivation of Liberty Safeguards (DoLS). DoLS are part of the Mental Capacity Act 2005. These safeguards aim to make sure that people are looked after in a way that does not inappropriately restrict their freedom. In England, the local authority authorises applications to deprive people of their liberty. The manager told us that between February and March 2015; she had submitted 18 DoLS applications to the local authority to authorise. This information was documented in people's care plans. There had been a delay by the local authority to authorise these, because of the volume of applications they had received from providers throughout Northumberland.

We noticed that two people who lived at the home were subject to section 117 of the Mental Health Act (MHA) 1983. Section 117 entitles people to free aftercare support such as accommodation and treatment. Section 117 only applies if people were previously detained in hospital under certain sections of the MHA. Aftercare will only stop when people no longer require any more support. There appeared to be a lack of clarity and understanding in relation to the legal status of these two people. The manager told us that these people did not require DoLS assessments because they were subject to aftercare arrangements under section 117. When a person is subject to section 117 and is residing in a care home, consideration of a standard authorisation relating to DoLS should be considered as part of their aftercare package. The manager told us that she would look into this issue. Following our inspection, the regional manager wrote to us and stated, "Following discussion with CPN [community pyschiatric nurse] care manager and DoLS team, the decision was made that DoLS applications were required and these were submitted on 18.05.15."

We noticed that decision specific mental capacity assessments had been carried out for "decision specific" decisions. There was evidence that best interests decisions were carried out and care plans were written in conjunction with people, relatives and health and social care professionals. This was confirmed by a community psychiatric nurse who we spoke with.

Relatives were complimentary about the meals provided. One relative said, "I come in every day to feed [relative]. He has to have puréed meals - all nice. He eats everything." She added, "I have my meal with him every day, it is almost too good!" Another relative said, "My only complaint is they feed him too well, the food is so good. They had homemade banana muffins yesterday with icing at teatime." Other comments included, "There are generous portions and meals are well cooked" and "They try and make meals special." We looked at comments which had been posted on an online independent care homes guide. One relative had commented, "As I go in at lunch time to feed my wife, the quality of the food and the choices are excellent."

Good

Is the service effective?

We saw that great emphasis was placed on mealtimes. One member of staff told us, “It’s important to make sure they have a good meal which is why we never rush. It’s also important socially for them.” We observed the lunchtime meal and saw that staff showed people both meal choices. One care worker said, “Look, this is the fish and this is the sausage, what do you fancy?” This meant they could see and smell the food which was particularly beneficial to people who had a dementia related condition. Pictorial menus were also available to help people visualise the planned meals. We saw that lunch was a sociable event. Relatives were welcomed and some supported their family member with their meal. We saw that the maintenance man sat with people and had his lunch. Second helpings were offered before dessert. In the afternoon, we saw that people were able to have homemade smoothies and freshly made cupcakes.

We spoke with the cook who was very knowledgeable about people’s needs. She spoke with people after each meal to find out whether they had enjoyed the food. If people were unable to communicate verbally, she would check to see how much of the meal they had eaten to gauge whether they had enjoyed it or not. She said, “It gives us a good idea about what they like to eat…We cater for everyone differently. We buy in Belvita biscuits for one resident because she likes to dunk them in her tea and [name of person] has an amazing appetite, so we always have snacks available like crisps for her to munch on. [Name of person] is on a reduced calorie diet so we give him strawberries which he likes and chopped carrots. We try and cater for everyone; I think it’s my motherly instinct.”

We checked the cook’s “day book” where she documented feedback about the meals. We saw comments such as, “Said beef stew was beautiful” and “Had pureed beef, ate it all.” The cook told us and our own observations confirmed that some people required a pureed diet. She explained that each part of the meal was pureed separately and placed on the plate in distinct portions to make the meal look more appetising. She said, “It has to look nice on the plate.” We noticed that thickener was used where required in some people’s drinks which had been advised by the speech and language therapist.

The local authority sent us a copy of their report following their unannounced visit to the service in February 2015. We read under the title, “Positive practice” was recorded, “Positive staff interaction noted when assisting residents with their meals.”

We noted that people were supported to access healthcare services. We read that people attended GP appointments; consultant appointments; saw the community psychiatric nurse; dentist, optician and podiatrist. The GP told us, “We do weekly visits here and when needed. They always contact us appropriately.”

We checked how the adaptation, design and decoration of the premises met people’s needs. The manager told us that many of the people who lived at the home had a dementia related condition.

The National Institute for Health and Care Excellence (NICE) states, "Health and social care managers should ensure that built environments are enabling and aid orientation."[NICE, Dementia - Supporting people with dementia and their carers in health and social care, November 2006:18]. We found that all of the premises were “enabling” and helped aid orientation.

All the corridor walls were themed and were decorated with interesting items. There were pictures from old movies with clothes pinned to the wall. There was a “Singing in the rain” theme along one of the corridors. Beside the themed wall, there were wellies and umbrellas. Wartime memorabilia; handbags; gloves; gardening tools and pictures were also situated at various strategic places around the home. All items were able to be touched, taken down and carried. There were pretend light switches and pulleys to switch on and off and pull. We looked outside and saw that the secure courtyard garden had been turned into a stimulating environment for people who had dementia. We noticed that the garden walls had been painted with pictures of local scenes such as the quayside.

Outstanding ☆

Is the service caring?

Our findings

We asked people the question, "Are staff kind?" Those that were able to understand nodded their head in agreement to the question. Relatives were complimentary about the care provided. One said, "The care is exceptional. I can't praise them enough. The care never drops…They will say, 'What is the matter sweetheart?' If anyone is upset." Other comments included, "I couldn't have found a nicer home with nicer staff. They persevere and are very kind and gentle" and "The girls deserve a medal in here for what they do, they are marvellous."

We looked at written compliments which had been received. One relative had stated, "We appreciated the outstanding care from all of you…We get comfort to know she was happy the last few months." We looked at comments which had been posted on an online independent care homes guide. One relative had commented, "The staff are really friendly and helpful, always dedicated to the residents and very caring towards them." Another relative had written, "My wife has been a resident for a year, I visit on a daily basis. I have always found the staff, caring, friendly and attentive. All the staff have the best interests of the residents at heart."

Health and social care professionals were positive about the staff. The GP said, "Their quality of life here is good. The nursing care is good and they have always had excellent care staff." He also said, "If I had severe dementia, I would want to come here" and "It's the carers that make it. They're very good, they've been here years." A social worker said, "The interactions are lovely. I visited the home to review one person and I could hear what was going on."

We noticed positive interactions, not only between care workers and people, but also other members of the staff team. We saw the maintenance man arm in arm with one person walking along one of the corridors. He told us, "This is an important part of my job too. I always stop off in between doing my jobs to chat with people." We also saw him giving chocolate to a person who kept saying, "Give us some chocolate!" We saw the cook and kitchen assistant at various times of the day sitting in the dining room talking to a person who had become upset. They got her a cup of tea and held her hand and talked about what was happening to help take her mind off being upset. She soon started smiling as other staff came over to her remarking how smart she looked. We observed one person looking after a doll which appeared to give her comfort. One member of staff said, "She loves this doll. We had a lot of problems distracting her or getting her to concentrate before, but as long as we have this doll, she is as happy as can be." The regional manager interacted with people frequently throughout the day. Some people reached out for a hug which was immediately given.

Staff displayed warmth when interacting with some people whose behaviour could be described as challenging. Staff were very tactile in a well-controlled and non-threatening manner. The manager said that all of the staff were understanding and showed patience with people. This was confirmed by our observations. She said, "The team go that extra distance to get it right."

Staff spoke with pride about the importance of ensuring people's needs were held in the forefront of everything they did. One staff member told us, "This is why I do this job – for the residents." Another said, "It's a pleasure to come to work, to see all my ladies and gentlemen." Other comments included, "I am passionate about this home" and "It makes it all worthwhile, seeing their faces."

People's care plans documented people's likes and dislikes. We read one care plan which stated, "I enjoy one to one interactions and having lots of cuddles for comfort. I like to be well dressed with my makeup on each morning. I enjoy having my hair done." We met this person and saw that the care documented in her care plan reflected the care provided by staff. Staff spent time with her, walking arm in arm along the corridors. She looked well-presented and she showed us her jewellery which she was wearing. On occasions she got upset and staff gave her a cuddle, held her hand and got her a cup of tea.

Staff were knowledgeable about people's needs and how to meet these. One care worker said, "[Name of person] was a builder, so we ask him to check the walls and doors to see if he thinks they are alright. [Name of person]] used to play for Ashington football club, he has a medal in his room, which we talk about with him."

Staff promoted people's privacy and dignity. This was confirmed by relatives. One relative said, "There is respect there. They [staff] say hello and they are genuinely nice." We observed that staff knocked on people's doors before they entered and spoke with them respectfully. Staff told us that one person was receiving end of life care. The room had a door buzzer fitted to alert staff if any person

Outstanding ☆

Is the service caring?

accidently “wandered” into his room. This alarm helped ensure his privacy at this important time. We saw staff discreetly wipe people’s hands and faces after their lunch and people were supported to change any items of stained clothing. We heard one person complaining of pain. Staff assisted her to a private area in order for the nurse to check her over.

There were a number of feedback mechanisms in place. “Residents and relatives’ meetings were held. One relative said, “I come if I can, it's great how they get people’s views from them all.”

Good

Is the service responsive?

Our findings

Relatives told us that they considered staff were responsive to their family member's needs. One relative said, "She is better now than when she came in. I have never had any trouble. I can talk to anyone [staff] and I come in everyday." Another relative said, "He [person] has been in hospital recently and when he came back the GP came in the same day. I am always consulted about care." Other comments included, "They sent her in here as palliative care and one year later she is better than ever," "I have been consulted about everything. He has come here from the challenging behaviour unit. Finding somewhere suitable was hard," "They have given me my wife back," "They are really on the ball. When she gets agitated they check and send a sample of urine in case she has an infection. They persevere until they get a sample" and "They seem to be aware if she gets more agitated and they phone me up if anything is different."

Health and social care professionals were complimentary about the service. The GP said, "They have improved [name of person's] life brilliantly" and "They go that extra mile." We conferred with a continence advisor from the local NHS trust. He said, "We receive written referrals from them. We request a six page assessment and they complete this appropriately. We also need a fluid input and output and bowel chart which they also complete…[Name of deputy manager] is very into [continence care] which is good. It's so important to have someone who's interested in continence because it's so important for people. It's one of the nicest homes to come to because of the input from staff." The community psychiatric nurse said, "We do assessments and agree a plan of care with the home…They are really quite proactive and look at different ways to work with people. I work with the nurses to agree the plans of care. I have no concerns." A team manager from the local NHS trust told us that she did not have any concerns about the service and staff contacted them appropriately and in a timely manner.

We spoke with a community matron for nursing homes. She said, "They deal well with a lot of people who have quite complex situations. The carers are very stable and have been there a while. The two seniors who are in place are fantastic." She told us about the home's involvement in the "Position Right to Outsmart Pneumonia" [PROP] pilot. This pilot was aimed at helping to reduce the risk of acquiring pneumonia and involved staff raising the heads of people's beds to 30 degrees. She explained that people's lungs do not work as well if they are lying flat which increases their risk of infection. We saw that information was displayed around the home about PROP and staff were knowledgeable about the correct positioning of people in bed when we asked.

We saw that emergency health care plans (EHCP) were in place in some of the care plans we looked at. An EHCP is a document that is planned and completed in collaboration with people and their GP to anticipate any emergency health problems. The GP told us, "They're responsive…We have emergency health care plans to try and avoid them going into hospital. This means any hospital admissions are appropriate."

We noticed that the challenging behaviour team had been involved in one of the people's care plan's we viewed. The Newcastle Model of Challenging Behaviour was used to explain the person's behaviour. This model provides a framework to help staff understand the cause of a person's challenging behaviour and places the person who is living with dementia at the centre of the assessment and intervention process. In addition, the model provides a process by which interventions should be delivered. We spoke with a challenging behaviour clinician who explained that instead of resorting to medicines with immediate effect, staff looked for the possible reasons behind the challenging behaviour and used behavioural and environmental solutions to the presenting issue. These procedures were in line with the National Institute for Health and Care Excellence (NICE). This was confirmed by the GP who said, "They manage people as people. Instead of dosing them up [on sedatives] they are aware of their foibles – foibles are good, they show a person's personality."

We noticed staff in all job roles knew people's likes and dislikes. We heard a member of domestic staff say to a person, "I have switched your organ on for you and moved it forward." She told us, "We went with him to get that [electronic organ] for him. He plays a lot, not so well nowadays, but he was really good. He gets everyone going." We saw care workers singing and dancing with people, moving in a rhythmical way which appeared to have a soothing effect on people as well as being a form of

Good

Is the service responsive?

exercise. Staff spent time with people on a one to one basis. They told us that this was important to people. One staff member said, "We try and vary things, but a lot now is one to one contact and stimulation."

Staff told us that one person was a heavy smoker. They explained that he used to smoke outside, however this presented a falls risk and the consumption of so many cigarettes was also affecting his health. Staff asked whether he would like to try using an electric cigarette. Staff told us and our own observations confirmed that this suggestion had worked. We read his care plan which had been updated. This stated, "[Name of person] now using a smokeless cigarette which he finds much easier to manage."

An activities coordinator was employed. She spoke enthusiastically about ensuring that people's social needs were met. She told us that she had regular meetings with a local activities charity to discuss ideas for activities. She told us, "Some of the residents don't like group activities; they prefer one to one sessions like my aromatherapy sessions and hand massages." She told us those that wanted to, went to a local social club every Friday and the hairdresser visited on a Monday. None of the relatives with whom we spoke raised any concerns about activities provision. One relative said, "They seem to do a fair few things."

We saw that each person had a memory box in their bedroom which was filled with items which were important to them such as jewellery, photographs and DVD's. Staff told us that they used these boxes to facilitate conversations and as an aid for reminiscence. This was confirmed by some of the relatives with whom we spoke. One said, "I helped make a memory box and they often go through it with her."

There were no staff based upstairs and most of the people who lived upstairs, were assisted downstairs to socialise and sit in one of the two ground floor lounges. We checked to make sure that everyone was able to access their own personal space when they wished. We spoke with a relative whose family member lived upstairs. She told us she had no concerns about this arrangement and said, "She likes to go downstairs and see what's going on."

The regional manager stated that people were supported to come downstairs, "So that they are less socially isolated due to reduced occupancy levels on the upper floor resulting in reduced socialisation and day to day contact with other residents." We saw one person was supported to go upstairs to their room after lunch and spend time with her relative. This meant that people were supported to access all areas of the home and action was taken to help prevent social isolation.

Relatives were complimentary about the service and had no complaints. One relative said, "I have no complaints about his care." Other comments included, "They're like gold the girls in here - no complaints about care" and "I can come when I like, I am in every day. I would know how to complain, I would see the manager but there is never anything."

A complaints procedure was in place. Four complaints had been received within the past 12 months. Records were kept which documented what actions had been taken to resolve the issues which had been raised. There was evidence that complaints were analysed to ascertain whether there were any trends or themes; none had been identified.

Requires improvement

Is the service well-led?

Our findings

There was a manager in place who had been in post since September 2014. She had been a registered manager with a previous provider before coming to The Oaks Care Home. The manager was in the process of registering with CQC to become a registered manager. She had completed her "fit person's interview" with a CQC registration inspector and was awaiting the final decision in relation to her application. A deputy manager had recently been appointed a few weeks before our inspection. A regional manager oversaw the management of the service.

The manager explained that the service had gone through a period of significant challenge since she had taken up the post of manager in September 2014. Occupancy levels had fallen following a number of expected deaths.

Most staff informed us that more support from the manager would be appreciated and commented that morale was sometimes low. Some relatives informed us that she was not as approachable as the previous manager. One health and social care professional told us, "She is different to [name of previous manager]. She is very nice. She is upfront and just has a different management style."

We spoke with the manager and regional manager about this feedback. Following our inspection, the regional manager wrote to us and stated, "The home was without an onsite daily manager for a period of a few months prior to [name of manager's] start. Upon starting employment, certain issues arose that required direct attention and action from [name of manager]. This involved invoking and initiating self-reporting, openness and transparency of issues identified. Once identified the manager had to lead the team through a difficult period of review, lessons learned and demonstrate positive change to practise…[Name of manager] will continue with daily walk arounds of the home and during these times will spend time talking with visiting relatives to develop a positive relationship rather than concentrate solely on observational techniques."

As part of our inspection, we spoke with six members of night staff to find out their opinions about working at the home. They informed us that the relationship between day and night staff was sometimes not good. We spoke with the manager and regional manager about this issue. The regional manager stated, "This internal unrest had been identified by [name of manager] on commencement of employment in her role as home manager and in February of this year she commenced a programme of internal rotation…The process commenced with agreement from staff and the purpose of this was to dispel the day shift/ night shift divide and allow each employee the opportunity to fully understand the working practises on days and nights and also to obtain a holistic understanding of the care needs of every resident which often changes between day time and night time."

A staffing tool was used to assess staffing levels at the home. The manager told us however, that this tool did not take into account the needs of people who had a dementia related condition. We spoke with the regional manager about this issue. She said that they were addressing this and were going to amend the tool to ensure that it correctly assessed staffing levels based upon the dependency levels and needs of all people who lived at the home.

There were systems in place to communicate with staff across all operations. There was evidence of monthly staff meetings and all staff confirmed they had the opportunity to include items on the agenda. Additionally, 'Flash' meetings were held where the manager met with the head of each functional area such as the nurse; cook; housekeeper and maintenance man. These meetings were held daily and any issues or concerns were discussed and acted upon as necessary.

The manager carried out a number of audits and checks to monitor the quality of the care provided. These included checks on care plans, medicines, the dining experience and health and safety. Where deficits were identified; corrective actions had been implemented. We read one recent medicines audit which had highlighted an issue with one person's "as required medicine." The medicine had been administered without an explanation being recorded. Awareness was raised with appropriate staff and this was subsequently re-assessed. We viewed a dining experience audit which identified people were using cups which were heavily stained. This was deemed unsatisfactory and new cups were obtained. We found however, that it was not always clear what actions had been taken when concerns or issues were highlighted during checks and tests of the premises. This was because the external maintenance

Requires improvement

Is the service well-led?

contractor did not record the work which had been carried out on the provider's computer portal. The regional manager told us that they were aware of this issue and were looking at ways of addressing this.

The home had achieved the silver standard of the PEARL accreditation scheme. PEARL stands for Positively Enriching and Enhancing Residents Lives. The PEARL programme is an accreditation scheme specifically designed by the provider to ensure that services are providing the most up to date training, communication and interventions for people living with dementia.