HC-One Limited

Oakland (Rochdale)

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

Oakland Rochdale (referred to in this report as Oakland) is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. The Care Quality Commission (CQC) regulates both the premises and the care provided and both were looked at during this inspection.

This inspection took place on 25 and 27 September 2018. Our visit on 25 September was unannounced. The home is registered with CQC to provide nursing and personal care for up to 40 older people. At the time of our inspection there were 39 people living at the home. Accommodation is provided over two floors, with capacity for 18 people in a dementia unit on the ground floor, and 22 people in the residential unit on the first floor.

We last inspected this service in August 2017 when we found the registered provider was in breach of Regulations 9, 10, 17 and 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because people were unable to pursue their individual hobbies and interests; their personal care needs were not always attended to, there were insufficient staff to meet people's needs safely and the overall governance of the service had not been effective in improving the service. After our last inspection the provider sent us an action plan telling us how they would improve the service. These improvements had been effective, and we found the provider was now compliant with the regulations and consistently meeting people's needs.

The service had a registered manager who had been appointed immediately prior to our last inspection. They have completed the registration process and registered as the manager with the Care Quality Commission (CQC). A registered manager is a person who has registered with the CQC 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.

People told us they felt safe at Oakland. Risk assessments identified and monitored individual and environmental risks and the registered manager conducted a daily walk around of the property to identify any maintenance issues or other concerns which were reported for repair. People told us, and we saw that staff took appropriate precautions when delivering care and the staff we spoke with understood their roles and responsibility to safeguard vulnerable people. They had a good understanding of safeguarding issues, and there was a system in place to report any suspicion of abuse.

Most of the people who used the service were unable to consent to their care and treatment, but the people supporting them at Oakland understood issues around capacity, and offered meaningful choices in a way people understood. Where people were unable to consent, the appropriate deprivation of liberty authorisations had been sought.

At our last inspection we found that there were not always enough staff to safely meet the needs of people who lived at Oakland. We found at this inspection that the service had developed a dependency chart to determine the right level of staff. There were sufficient staff on duty to attend to people's needs and provide care and support in a timely and respectful way. They were well trained and had access to refresher training to ensure that their knowledge was up to date and in line with current best practice. The service made appropriate checks during the recruitment process to ensure that new staff had the right attributes and character to work with vulnerable people. All new staff received a full induction and systems were in place to provide one to one supervision for all the people who worked at Oakland.

We saw that care staff knew the people they supported and staff told us that they felt comfortable working on either the residential or the dementia unit. Care plans reflected people's needs and interventions were kind, patient and timely. People had call bells to summon assistance if needed; we heard when these were triggered that their needs were quickly attended to. The staff we spoke with could tell us about the needs, wishes and characteristics of the people they supported and spoke about them in a caring manner. They showed a genuine caring attitude. Dignity, respect and personal choice was acknowledged, and people felt involved in their care.

There were systems in place to ensure that medicines were well managed. These included attention to people's skin integrity; records and charts gave very clear instruction to staff who applied creams and ointments.

The home was clean. Staff were mindful of their need to maintain a good level of hygiene and appropriate procedures were in place to prevent and control infection.

At the last inspection we found that care records did not always document people's hobbies and interests and that staff rarely had to spend with people meaning that they had little to do. Since that inspection the service had increased the staff ratio and appointed an activity coordinator. This had led to an improvement in activities and people were more stimulated.

We saw that attention was paid to people's general health, with regular liaison with doctors, district nurses and other health and social care professionals. Dental and optical appointments were made as necessary. Similarly, staff were attentive to what people ate and drank. Care records indicated any dietary requirements, and showed liaison with dieticians and Speech and Language therapists to ensure that people ate the correct foods in the way that would minimise risk, for example, of choking.

We saw that systems to monitor the quality of the service provided had improved since or last inspection. To help ensure people received effective care checks were undertaken on the running of the home and there were opportunities for people to comment on the facilities and the quality of the care provided. Records showed that systems to manage complaints, incidents and accidents were managed well and measures put in place so that they were less likely to reoccur.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

People told us they felt safe, their needs were met promptly and they had peace of mind.

There were sufficient staff who were safety recruited and knew how to protect people from harm.

There were appropriate systems in place for the effective ordering, control, management and administration of medicines, and systems ensured that creams and ointments were applied according to instruction.

Is the service effective?

Good

The service was effective.

Staff were well trained, and knowledgeable. They communicated well with each other to ensure care needs were met in a consistent manner, and had regular supervision.

People enjoyed the food provided, and had good access to healthcare. Staff monitored their physical and mental health needs.

Staff showed an understanding of capacity and consent issues. Where people were being deprived of their liberty the registered manager had taken the necessary action to ensure that people's rights were considered and protected

Is the service caring?

Good

The service was caring.

Care and support was tailored to meet the individual needs of the people who used the service.

Staff were kind and caring and encouraged people to make decisions within their day to day lives.

There was a calm and relaxed atmosphere and staff showed

concern for people's welfare.

Is the service responsive?

Good

The service was responsive.

Care records provided enough detail to guide staff on the tasks required to support people in the way they liked to be supported.

People told us that they had enough to occupy their time, and there were a variety of activities on offer.

The service responded well to any formal or informal complaints.

Is the service well-led?

Good

The service was well led.

There was a registered manager in place who had helped to promote a caring and supportive culture at Oakland.

People who used the service and their visitors had opportunities to comment on the quality of service delivery.

Good systems of quality assurance were in place.

Oakland (Rochdale)

Detailed findings

Background to this inspection

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

This was an unannounced comprehensive inspection and took place on 25 and 27 September 2018. It was carried out by one inspector, an assistant inspector and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

We used information the provider sent us in the Provider Information Return (PIR). This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We looked at the information in the PIR and other information we held about the service before the inspection visit. We contacted the local authority infection control, safeguarding and commissioning teams to obtain their views about the service. We received positive feedback from teams we contacted.

During our visits we spoke with ten people living at Oakland and five visiting relatives. We spoke with staff, including the registered manager, the area director and area quality director, six care staff, the service administrator, the activity coordinator and a chef. The registered manager was present throughout our inspection. We also spoke with two visiting health and social care professionals,

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us to understand the experience of people who cannot talk with us.

We looked around the building including some of the bedrooms on each floor, all the communal areas, toilets, bathrooms, the kitchen and the garden areas.

We examined the care records for six people living at Oakland, and daily log sheets for a further four; six medicine administration records the recruitment and supervision records for six staff, training records, and records relating to the management of the home such as the quality assurance systems.

Good

Is the service safe?

Our findings

People who lived at Oakland told us that they felt safe and this gave them peace of mind. One person told us, "The staff are very good. I feel safe and I can trust the staff. The staff listen." Another told us, "I do feel safe here because I can use my buzzer and the carers come quick. The best thing about this place is that if you need support, someone is there for you. Visitors agreed; one visitor, the friend of a person who used the service, told us they visited once or twice each week and remarked, "I think this home is very safe and pleasant for the residents. The staff members are very good. [My friend] has been happy here and that's the main thing."

We saw that the home was secure. When we arrived for our inspection we were asked to show our identity badges and to sign the visitors book. The entrance was kept locked, with access via a secure key code; this ensured that unauthorised people would have difficulty entering the home, and that staff were aware of who was in the building at any time. There were two stories, two sets of stairs and a lift, all protected by pin codes. One set of stairs was intended as a fire escape, rather than for regular use, and had an alarmed pin pad. As we walked around the building we saw there was good colour contrast between walls and floors and corridors were free from obstacles which might hinder people with poor vision or mobility. When we looked in bedrooms we saw call buzzers were situated where people could reach them but noticed they had metal clips to attach the buzzers either to clothing or bedding. The potential risk of skin abrasions from these was raised with the registered manager and area director, who agreed to look into this matter.

We observed staff were vigilant to people's welfare and safety. For example, we saw that when transferring people using hoists and other mechanical aids staff used this equipment effectively, and took care to ensure that transfers were safe. When call bells sounded, care workers were quick to respond.

The service had policies and procedures to protect vulnerable people from abuse, and all staff had been trained in safeguarding adult procedures. When we asked them, they told us that they knew what signs to look out for, and how to respond. One care worker told us that they had recently been concerned that a person they supported was being abused after the person disclosed information to them. They raised this as a safeguarding concern which led to a police investigation. We saw that when alerts had been made appropriate steps were taken to protect the individual, and to investigate incidents to avoid any future reoccurrence.

We looked at six care records, which showed that risks to people's health and well-being had been identified. These involved risks such as mobility, eating and drinking, nutrition and hydration, communication and hygiene. Where risk was identified we saw appropriate referrals were made to relevant health and social care professionals, such as falls coordinators or dieticians. Subsequent care plans referred to any instruction provided, and identified any aids and adaptations to minimise the risk, including use of equipment. For example, crash mats were placed next to some people's beds, so if a person were to roll out of bed the risk of injury would be reduced. Call bells were accessible to allow people who used the service to summon help.

We found systems were in place to enable staff to respond effectively in the event of an emergency. There was a fire risk assessment in place, and we saw that personal emergency evacuation plans (PEEPs) had been developed for the people who used the service. These plans explain how a person is to be evacuated from a building in the event of an emergency evacuation and take into consideration a person's individual mobility and support needs. The service also had a business continuity plan in place. The plan contained details of what needed to be done in the event of an emergency or incident occurring such as a fire or utility failures.

Records showed that equipment and services within the home were serviced and maintained in accordance with the manufacturers' instructions. This included checks in areas such as gas safety, portable appliance testing, fire detection and emergency lighting. This helps to ensure the safety and well-being of everybody living, working and visiting the home. The manager kept a schedule which showed when servicing was required for the call system, lift, fire extinguishers and alarms, profiling beds, boiler and gas cooker and the service minibus. Portable appliance tests (PAT tests) had been carried out on all small electrical appliances to ensure their safety. This schedule also showed when full checks were needed for water temperatures and legionella testing. We saw that the legionella check had been scheduled for the week after our inspection.

When we last inspected the service in August 2017, we found a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as there were not enough staff to provide safe care. The area director told us that following that inspection the staffing levels had been increased, and the service used a dependency analysis to determine the number of staff required, based on the specific needs of the people who used the service. There were always seven care staff on duty during the day, and three waking night staff. There was at least one senior care worker on each unit at all times. In addition, the service employed four kitchen staff, five housekeepers, a maintenance officer and a 'well-being' officer who supported and arranged activities and daily stimulation. People told us that they believed there were enough staff to meet their needs. We saw gaps on the rota due to holidays and sickness were covered by agency workers, but the registered manager told us that they always used the same agency staff, which ensured that they were familiar with the people who lived at Oakland and knew how they liked their needs to be met. The service was no longer in breach of this regulation.

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

Medicines were stored and administered safely. All medicines were kept in a treatment room which was locked when not being used. Only staff who needed to had access to the keys. Both the fridge and room temperatures were recorded daily. If medicines are stored at the wrong temperature they can lose their potency and become ineffective. Medicines were dispensed from a lockable trolley by senior care workers who had been trained and had yearly competence checks. Medicine rounds were conducted in a timely fashion to ensure that medicines were administered at suitable intervals. This helped to ensure that people received the right medicines at the right time.

Controlled drugs were appropriately stored in a further locked cabinet. These are medicines named under

misuse of drugs legislation which restricts how such medicines are stored and recorded. The controlled drug register was countersigned when administered. We checked the balance of controlled drugs for one person and found them to be correct.

We looked at medicine administration records (MARs) for 6 service users and found they had been completed accurately with no gaps in recording. The medication counts were consistent with the recordings on the MAR. Where medicines were prescribed to be taken 'as required' there were instructions which gave details including the name and strength of the medicine, the dose to be given, the maximum dose in a 24-hour period, the route it should be given and what it was for. However, we saw that the protocol for one person was missing. We raised this with the registered manager who explained that this had not been transferred across when the MAR had been updated for this cycle and they were able to rectify this oversight.

Where people had been prescribed creams and ointments these were administered by care staff and recorded on a separate topical medicine administration chart (TMAR). We saw these were recorded accurately and each TMAR included body maps highlighting the specific area on the person's body where creams were to be applied; one for each cream. Records clearly indicated which cream was required, and where and how it should be applied.

The medicines system was audited by staff daily with a further monthly check by managers to ensure safe management of medicines. Staff retained patient information leaflets for medicines to check for information about medicines such as side effects.

Prior to our inspection we contacted the local Infection Prevention and Control Team, who sent informed us that they were satisfied with the steps taken at Oakland to minimise the spread of infection. We looked around all areas of the home, and saw that it was warm and light, clean, free from any unpleasant odours and well maintained. One relative told us, "This is our first visit, but it seems a very nice home. What I particularly noticed was the lack of 'care home smell'. It smells clean and fresh here."

Communal bathrooms were clean and hygienic. They were decorated in pastel shades which gave a homely feel to them. We saw that where dangerous or hazardous equipment was stored, doors displayed warning signs and 'keep locked notices'. When we tried these doors, we found that they were locked. We saw that toilets had posters detailing safe hand washing techniques, and that soap;, paper towels, disposable aprons and hand gel were available, further reducing the risk of cross contamination. In the laundry, we saw that there was a separate entry and exit and soiled items were appropriately washed separately from other items of clothing, preventing the risk of cross contamination. The kitchen was clean, and kitchen staff regularly monitored the fridge temperatures and stored food safely to prevent any risks of cross contamination or food wastage. The kitchen was awarded the highest food hygiene rating from the Food Standards Agency.

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

Staff were encouraged to report any accidents and incidents and we saw that over the previous month there had been 12 reported incidents. Records gave details of interim action to ensure the safety and well-being of the people involved, or immediate action to resolve the issue. The registered manager told us that reported incidents provided an opportunity to improve the service; each incident was reviewed and follow up action was taken to consider any further action which could be taken to minimise the possibility of a repeat

occurrence. We looked at one incident which was reported appropriately and raised as a safeguarding concern. Following a full investigation into the incident action was taken, including a general review of safety procedures. Individual supervisions addressed lessons learnt from the incident and a review of staffing helped to ensure the incident would not be repeated.

Good

Is the service effective?

Our findings

Oakland is owned and managed by HC-One, a company which manages many similar services across the country. As such the service had access to a range of resources allowing the registered manager and staff to keep up to date with new research, and ensure care and support was delivered in line with current guidance. The registered manager also remained abreast of local initiatives and liaised closely with the local authority and health service commissioners. The majority of the people who used the service, not only on the dementia unit but also on the residential unit were living with dementia, but when we spoke with staff about this they were not always able to tell us what kind of dementia had been diagnosed, nor how this might impact on their daily lives. The registered manager had recognised this gap in knowledge, and informed us that they were arranging for staff to develop their knowledge around dementia, and would be attending further dementia training.

When we spoke to people who lived at Oakland about the staff they told us they felt they were competent and well trained. One person said, "If you need support, someone is there for you. I think that any of the carers can help."

We saw that staff knew people well, and had the right skills and knowledge to carry out their roles. All new staff completed a comprehensive induction where they received training in essential aspects of the job, such as moving and handling, safeguarding, emergency procedures, infection control, and dignity training. They were shown equipment used and instructed on how to operate it. They would then spend time 'shadowing' a more experienced member of staff before they could work on their own. This enabled them to meet the people who used the service, understand their specific needs, and how best to respond.

We were shown a computerised schedule which demonstrated that staff had enrolled on or completed specific courses. New care workers were enrolled on the 'Care Certificate'. This is a nationally recognised qualification for people working in the caring sector.

Much of the training was delivered electronically using on-line courses. The staff room had two computers for staff to access, or they could be done from home if they preferred. The system also noted when refresher training was due and would automatically generate an email or text message to alert the registered manager and the staff member. When we inspected the online system it showed that 96.4% of the training was completed overall.

Further training was also available, if people felt they needed it, or if it would be beneficial. For example, one care worker told us that they had recently attended a three-day course and practical assessment to become a moving and handling facilitator, whilst another informed us that they had been considered for enrolment on the 'stepping up' leadership programme, which supported their career development and provided a route into management. They told us, "It gives you an insight and that little bit more information to understand the residents better." Another care worker listed a number of training courses they had completed, remarking, "The training is really useful; we learn about new things coming out."

The online training system also informed staff when they were due a supervision. Supervision meetings provided staff with an opportunity to speak in private about their training and support needs as well as being able to discuss any issues in relation to their work. The staff we spoke with told us that they received regular scheduled supervision, and would also receive supervision in response to incidents that occurred affecting their work. The registered manager provided a list showing staff members who were due for a supervision and those who were up to date. We looked at records for supervisions which had taken place in July and August. These were detailed and showed that staff had been involved with the process. We also saw that all staff had a yearly appraisal which provided an opportunity to discuss progress over the preceding months with their supervisor and consider areas of strength, areas of improvement and opportunities for development.

When we looked at care records we saw attention was paid to dietary needs. People were weighed regularly and Malnutrition Universal Screening Tool (MUST) scores were regularly reviewed. MUST is a commonly used screening tool which helps identify adults who are at risk of malnutrition or obesity. Referrals to dieticians or speech and language therapists (SaLT) were noted and advice recorded, with attention paid to ensure food was prepared to meet diet and nutritional requirements. Where risk had been identified we saw food intake charts were used to monitor how much or how little people were eating and drinking.

People told us that they enjoyed the food on offer. One person commented, "There's always something that I can eat, and the staff now know my preferences. There's definitely enough to eat and drink."

We saw residents had a choice of meals. People were served breakfast as they got up. The main meal of the day was served in the early evening, and a choice of hot or cold meals was available at lunchtime. Supper was offered before people retired for the night and tea, coffee and snacks were available in between meals.

We observed the lunch-time meal on both the residential and the dementia units. Both dining areas were well lit. The tables were laminated with a wood-effect finish, silver cutlery, clear drinking glasses and grey and white placemats. The crockery was white and there were pink and white artificial roses in miniature white watering can shaped vases at the centre of each table. The white soup bowls, plates and pudding dishes offered good colour contrast, both with today's food and the table tops. There were no napkins or condiments on the tables, but people were offered clothes protectors. We did not see any specialised crockery, such as plates with raised edges which would help support independence for people who couldn't manage to wield cutlery in the usual way. Cold drinks were offered to all the residents with the meal.

Lunch was vegetable soup, then tuna, ham, turkey and cheese sandwiches with side salad, or jacket potato with cheese, tuna or beans, followed by profiteroles with cream and chocolate sauce. On both units a menu displayed the two choices of the day, but this was small and was difficult for people to read without reading glasses. There were no visual or pictorial prompts, but we saw on the dementia unit a care worker took both options over to each person individually and assisted them to decide which they preferred. On the residential unit, however, choices were offered verbally. We noticed one person did not understand what they were being offered, so found it difficult to make a choice.

Staff were vigilant at mealtimes and provided appropriate support and assistance as required. On the dementia unit, three care staff provided one to one assistance to people who were unable to feed themselves, sitting with the person, talking with them, establishing eye contact and helping them to eat and drink at their own pace. They encouraged conversation and people appeared to enjoy the dining experience.

Staff communicated well with each other and with external services such as adult social services, GP

services and district nurses. The registered manager told us that they had established good links with the local authority commissioning team and had found their advice useful and supportive.
Visiting health professionals told us that the service provided appropriate referrals and followed their advice. For example, one health care professional told us, "I've seen a big improvement. Staff are confident and follow instruction well. They know the people who use the service and are responsive when they aren't well. There are never any issues when I arrive, staff are all informative and supportive."

We saw that people had regular access to health care support when needed. One person told us, "If I was feeling unwell, they would send for the GP. The physiotherapist is seeing me regularly here and I am sure they would bring in any other healthcare specialists if needed."

People were registered with a GP and had access to podiatry, opticians and district nurses, where necessary. We saw that records were kept of any visits or appointments along with any action required. This helped to ensure people's healthcare needs were met.

When we looked around Oakland we saw that some effort had been made to meet the needs of the people who lived there. Since our last inspection the home had been redecorated and all old furniture had been replaced. A room on the first floor had been converted into a relaxing and well- equipped hair and beauty salon; one person we spoke to told us, "I love the hairdresser next door. I also get my nails done there and enjoy the pampering." There was a large lounge and separate dining area on each floor, and room for wheelchair access throughout the building. People had access to an enclosed grassed outside garden, and small seating areas allowed for private conversations.

People's names were on their bedroom doors but there were no photos or pictures on the doors to help people living with dementia recognise their own rooms. The service had recently introduced 'memory boxes' outside each room for individuals to place small items of meaning to them. These would help to orientate people to their rooms and provided an indication of the person's background or interest. Some of these boxes were still empty whilst others containing small personalised items, including photographs and trophies.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. The service had a detailed MCA policy and staff had been provided with training in this legislation.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

The service had an effective system for monitoring any applications and authorisations to ensure they were reviewed appropriately. When we inspected Oakland all the people on the dementia unit were subject to authorised deprivations. Where there were conditions to the deprivation we saw measures in place to ensure that these were met. Ten people on the residential unit had authorisations, and a further six applications to the local authority had been made.

Capacity assessments were held on people's care files to demonstrate that a formal capacity assessment

had been carried out before the DoLS application was made. Best interest meetings had been held to support the decision-making process for people who could not make decisions for themselves.

Staff we spoke with could explain the best interests process and when it was required. They were aware of the importance of asking people for consent before undertaking any care delivery. One care worker told us, "We ask. If they can, they choose clothes, choice of meals and what they want to do." They told us that they might offer advice and assist them with choices. Another person told us that people had a right to refuse, and told us that there were some people who used the service who would sometimes refuse their medicines. They told us that they did not want to administer the medicines covertly, so "I go back about twenty minutes later and offer again. Usually they take it then, but they can still refuse." We saw that when staff intervened to support people they would ask permission, for example, at lunch one person was asked if they would like a clothes protector, which they accepted, and people told us that they were offered choice. One person told us that the staff would ask permission before providing any personal care and another remarked, "The members of staff are polite and always ask for my permission. I accept this care gratefully, because it must be difficult for the staff at times."

We saw that people's care records had been signed by people who used the service where possible. The care files we looked at had individual capacity assessments for people's needs and this was reflected in people's care plans.

Good

Is the service caring?

Our findings

When we last inspected the service in August 2017, we found a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as people were not always treated with dignity and respect. Following that inspection, the provider sent us an action plan which detailed how they would improve this aspect of the service. At this inspection we saw that actions had been carried out and improvements had been made. The service was no longer in beach of this regulation. All staff had received training in dignity in care, and issues around respect had been addressed in team meetings and individual supervision. When we asked them, people told us that staff were kind and respectful, and that they were treated in a person-centred way. One person reflected, "I feel that I'm treated with courtesy. Staff always knock on my door. I think we're all treated as individuals." Another person told us, "Members of staff would give time to any of usand they treat us with dignity and respect. I'm quite independent; they respect that and don't try to do things for me that I can do myself."

All the staff we spoke with demonstrated a caring nature. A senior member of staff told us, "The staff come because they like being here, not because it's a job. They want to make people's lives a bit easier. I could not sing their praises enough," and a care worker remarked, "I'm proud of how everybody works and the care that we give."

Staff showed concern for people's well-being and promoted a calm and relaxed atmosphere. There were televisions in both lounges, but these were seldom switched on; instead, short activity sessions, tailored to the time of day, helped to provide stimulation, or a compact disc would be playing benefitting the mood and wishes of the people who used the service. For instance, before lunch on the residential unit we heard people singing along to songs from the fifties, and after lunch on the second day of our inspection we observed people sitting and listening to light classical music. One person sang along beautifully to an operatic aria. We observed staff were attentive to need, but allowed people their own space, and people appeared comfortable and relaxed. During both afternoons we observed cakes being offered to residents in the lounges. There was positive interaction between staff and service users, and a pleasant sociable atmosphere.

Care and support was tailored to meet the individual needs of the people who used the service. People were addressed by their preferred names and care staff spoke to people in a friendly manner making eye contact and touch where appropriate. Interactions between care staff and people who used the service were respectful and caring. A care worker told us, "Care here is person centred all the time. It's about the person, so it's not the same care given to everybody because everyone is not the same."

Staff were kind and caring and encouraged people to make decisions within their day to day lives. The staff we spoke with understood the needs and wishes of the people who used the service and supported them to maintain their lifestyle. One care worker us, "I know everything about every one of these residents." We saw several examples of how staff promoted people's choice with regards to activities, where they wanted to sit or if they wanted to stay in their rooms, and when and where they ate. People told us they had choices around when they wanted to go to bed or get up, and that staff encouraged them to do as much for

themselves as they could, and that their independence was promoted. One person who lived at Oakland said, "I am allowed to make everyday choices, for example I have wine or champagne every day." Another told us they liked to spend time in their room, and that this was respected. They said, "I'm happy here, I have no complaints. The staff are really good, they know I like peace and quiet, but they pop in to check on me."

All the people who used the service and the relatives we spoke with felt they could offer suggestions, make complaints, or express their views to the staff group without fear of any recrimination, and we saw that people were supported to access advocacy services when they did not have family members who could advocate on their behalf.

Privacy was respected, and we saw that people's personal belongings were treated with respect. The staff we spoke with understood when people needed privacy; one care worker told us, "Personal care is kept private. We close doors, and if a professional comes in we make sure they go to their rooms."

We observed that people were asked discreetly about their personal care. When people needed assistance with personal care we observed that staff ensured they closed doors in bedrooms and bathrooms. We noticed staff would knock on people's doors or ask for permission before they entered, and this was confirmed by regular visitors; one visiting relative told us, "I believe that [my relative's] privacy and dignity is respected, because they have always knocked on the door whenever I've been in this room with [my relative]. They have tried to support some independence, for example, they have encouraged my mother to dress herself." We saw that when a doctor arrived for a consultation with a person during a meal the person was having some difficulty. A care worker brought in a wheelchair to transfer the person from the dining area to their room for a private examination, and a white screen protected the person's dignity as they were transferred from dining chair to wheelchair.

Staff all understood that whilst Oakland was their workplace it was primarily people's home, and visitors told us that they were always welcomed. One visitor told us, "I think they're pretty good here. I usually come in the morning and have stayed through lunch from time to time. There has been no awkwardness about this. I've always been made to feel welcome," and another remarked, "It's very welcoming to be offered drinks on arrival, because we've had a long journey."

We saw when we looked at care plans that they recorded people's preference for support with personal care from a person of the same gender. They noted people's religion and sexuality, but none of the people who used the service had any specific cultural or religious needs. In an attempt to attract people from diverse backgrounds the service had recruited staff reflecting the makeup of the population and staff had received training in culture and diversity. When we asked them, they gave some examples of how they would support people from different ethnic backgrounds.

Good

Is the service responsive?

Our findings

Care was personalised and responsive to people's needs. A visiting relative recounted the issues which led to their relative being admitted to Oakland, including falls and poor health, but told us that the staff were attentive to need, and had responded well to changes in health. They told us, "I believe [my relative] is safe here and the staff are fine. She's having medical checks when they needed."

Care records provided enough detail to guide staff on the tasks required to support people. Where people had difficulties mobilising for example, care plans instructed staff on hoisting techniques, including use of the correct size sling and preferred side from which to be lifted. Records directed staff to provide care and support in accordance with their wishes, such as preferences for a male or female worker to assist with personal care. They allowed for people's independence and autonomy, for example one care plan instructed, 'Allow [person] to choose what to wear. Will require prompt putting on in right order.' Independence was encouraged, for example, we saw in another care plan, '[Person] will do her own make-up.'

All six of the care records we looked at showed that people and their families were involved in care reviews. Records documented discussion and views of the person and their relatives, any professionals involved in their care and any concerns or issues noted by the staff team. This helped to provide a clear understanding of any changes in need, which were then used to update care plans. Records were kept of any local authority reviews of care for people who were funded by their local authority.

Separate charts were kept monitoring any changes and interventions with people who used the service. Positional changes were documented for people when they were nursed in bed, with detail of the frequency of turns and position changes to minimise the risk of developing pressure sores. Food and fluid charts recorded the amount people ate and drank, and provided a daily total; hygiene records showed how personal care had been delivered and when people had showered or bathed.

Each day of the month the service would have a 'resident of the day'. This system allowed a co-ordinated approach to reviewing needs, so for the named person, the kitchen staff would review dietary and nutritional needs; housekeeping would complete a deep clean of the person's room and check equipment was in working order; the activity coordinator would look at activities and hobbies and consider how to ensure the person was stimulated. There would be a review and evaluation of care plans and risk assessments completed by the care staff. This included, for example, weight, medicine checks, and review of visitors. This system allowed the named person to have a converging review of their needs and meant that there was a co-ordinated approach across the service to meeting their needs. The staff we spoke with told us that reviewing care plans could be time consuming but, "It's worth it! We update care plans thoroughly and there is nothing in a care plan that you won't find. By the time you read that care plan, you will know that resident."

Care staff summarised interactions with people who used the service on a daily log sheet, but when we reviewed these entries we found they did not always contain enough information to reflect the interventions

we saw. For example, we saw repetitive care notes for different people, such as, 'X: settled day, no concerns' or 'Y: had a small but full diet today' which was repeated for other people who used the service.

At our last inspection we found a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as we found that there was little for people to do. Since then the service had recruited more staff which meant that care staff were freed from routine tasks and could spend more time on a one to one basis with people who used the service, or stimulating conversations amongst people. The service had also recruited a 'well-being' coordinator with responsibility for arranging and supporting social activity for all the people who used the service. A visitor told us that they had seen positive changes in the people who used the service since the well-being coordinator began working at Oakland. The well-being co-ordinator told us that they were building up relationships with the people who used the service, their likes and dislikes, hobbies and interests. They told us, "I'm getting to know people and how they are. [All have] different ways so I use different approaches, I recognise not everyone wants to participate in group activities, so look to find ways to work with them." We saw they kept a daily record of activities undertaken, and with whom, ensuring that all the people who lived at Oakland had a degree of stimulation every day.

They had introduced novel ways to keep people stimulated. For example, they had bought several chicks which, at the time of out inspection were kept in an incubator in the downstairs lounge, but had a chicken run and hen coop in the garden for when they had grown. People told us they enjoyed watching the chicks, and one person remarked, "I think it's a good idea to have the hens. No doubt we will be having fresh eggs soon. It helps to keep interest in different things, doesn't it?"

We saw that there were communal activities during our inspection to encourage people to remain active, such as batting balloons to one another and gentle 'pulse' exercises which aimed to maintain a level of fitness and flexibility. Levels of intervention were monitored and evaluated weekly. Other people were encouraged to maintain skills and hobbies, we saw a knitting circle and people making decorations with glue and crepe paper for Halloween. Care staff were encouraging residents in a warm and friendly manner. Our conversation with one person who used the service was shortened when a DVD film they had asked to watch was coming on. On the second afternoon of our inspection the service had arranged for a visiting entertainer. The people who attended this session appeared to enjoy themselves, and we saw care staff encouraged people to sing along and get up and dance.

People told us that they had enough to occupy their time, and they did not feel obliged to join in group activities which weren't to their taste. One person told us, "The staff are good here, but I choose to spend my time in my room. It's nice that they pop in and speak to me through the day." Another remarked, "I am quite happy with everything. I don't join in all the activities' in the lounges, but I have enough to do. They are giving me a facial massage this week. My family take me out. I know that I am lucky in that respect. There are some events where we are taken out into the community by the carers. For example, I went to see Mamma Mia 2 at the cinema with the carers. I really enjoyed it. They're also go to the pub from time to time, but that's not to my taste. I really enjoy music and dance". The registered manager told us that the service had a minibus, and this would be used to take people on trips, or visits to the local shops and markets, or occasional lunches out.

The service had a complaints policy which was displayed in the main foyer. Since our last inspection there had been five complaints made, all of which had been investigated, and copies of correspondence included acknowledgments and outcomes. Where complaints had been substantiated after the investigation, a letter of apology was recorded.

People told us the service responded well to any informal or general complaints. We asked a visitor if they

knew how to make a complaint, and they told us, "I would speak to the manager if I had a concern about the service. The home is very good about responding to any query.," Another told us that their relative was never ready when they arrived to take their relative for hospital appointments, but since they raised this with staff, "[My relative] is now always ready for us to collect and take to hospital for her appointment time." A person who used the service told us they had never complained but, "My clothes can go missing. We write the number of our door on all our clothes to help staff to return laundered items to the right residents. If anything goes missing, I can at least go to look for my clothes and I usually find them."

At the time of our inspection nobody was receiving end of life care but we saw complimentary cards from relatives who had spent their last years at Oakland, which praised staff for their kind and compassionate care. We asked care staff about how they supported people at the end of their lives and they gave good accounts of how people's last wishes had been respected, giving details of liaison with health professionals and support for family and friends. They told us that this was always a difficult part of their job, as they become attached to the people they are supporting on a daily basis.

When we looked at care records we saw some included a 'do not attempt resuscitation' form (DNACPR) but did not include any end of life care plans. A DNACPR form is a document issued and signed by a doctor, after consultation with the person and their representatives which advises medical teams not to attempt cardiopulmonary resuscitation. Care staff told us that although they acknowledged that most of the people living at Oaklands would spend the last years of their lives there, they were uncomfortable reminding them, or talking with them about how they would like to be supported at the end of their life. One care worker told us, "Maybe I don't want to accept that people are at the end of life, but when the time comes we try to support them and their families to ensure they have a dignified end."

We spoke with the registered manager about how service plans to support people as they approached their death. They agreed to review the service approach to end of life care, and to consider discussing and recording their wishes as a part of the initial assessment.

Good

Is the service well-led?

Our findings

There was a relaxed and comfortable atmosphere when we visited Oakland, and people who used the service looked, and told us that they were content. Staff told us that they enjoyed coming to work, one said, "I love it, working here. Everything feels right." They explained that they felt people were treated with respect and that the service operated at the pace of the individuals who used the service, and that staff worked well together. Another told us that they missed the people who used the service when they were not working; "We have a bond."

The service had a person registered as manager with the Care Quality Commission (CQC). A registered manager is a person who has registered with the CQC 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. The registered manager had been appointed immediately prior to our last inspection and had been in post for a year at the time of this inspection. Care staff told us they felt supported by the registered manager and that there had been improvements in the care and home in general. One said, "I feel properly supported, there is good teamwork and good management." People who used the service spoke well of the registered manager, one person told us, [The registered manager] is such a nice person, very approachable and competent as a manager. I would recommend this service. [The registered manager] does pop in regularly and checks to see how I am, which is nice." A visiting relative remarked, "This seems to be a well-managed service. It seems clean and bright. The staff are very welcoming, which I think counts for a lot."

We saw the registered manager engaged with people who used the service and their relatives, and encouraged staff to do the same. A visiting relative told us how the caring culture and attention given had helped their relative. They said, "The manager is very approachable. I'm afraid that I have nothing to compare this service with, but my mother does seem to like the carers. I think the best thing here is the friendliness of the carers and my mother will allow them to provide personal care, which is amazing. She wouldn't allow any similar assistance at home."

Staff told us that they had found the service to be supportive, and that it acknowledged their personal as well as professional needs. They told us that the registered manager had a good understanding of staff work life balance and that this was helpful when planning rotas, and that the office door was 'always open'; the manager would find time to listen to them. One said, "You can go in and talk to [the registered manager] any time." One care worker told us how they had been encouraged to take on more responsibility, and to 'challenge yourself', another told us how they had been supported to attend a course in British sign language (BSL).

The registered manager told us that they felt well supported by the provider. They told us, "HC-One (the provider) have been very supportive. Some staff didn't like changes in management and have moved on. Now we have more settled staff. The area quality director conducts audits and quality checks which have been constructive and useful, and my area manager has been supportive. This has all helped to improve the quality of the service." Prior to working at Oakland, the registered manager had experience in residential

care, but mainly with a different service user group. The area quality director informed us that the registered manager had demonstrated the skills to manage a home, and had been supported to understand how needs can differ. For example, identifying the risk of falls, and applying the information to specific characters in the home. In return, previous knowledge and experience around mental health issues had been beneficial to the service.

The service was keen to receive feedback from people who used the service, staff and other stakeholders, such as visiting professionals and service commissioners. A touch screen in the foyer allowed people to make comments about Oakland, and these were regularly reviewed, and outcomes were displayed on a noticeboard in a 'you said, we did' format, showing action taken as a result of comments. Similarly, annual surveys for staff and people who used the service were analysed and used to produce a report of findings. People who used the service were invited to regular 'resident meetings'. We looked at the minutes of the most recent meeting which showed a range of topics were discussed including activities, food provision suggestions for using the garden area and provision of a newsletter to keep relatives up to date.

Staff meetings were held every two months, but the registered manager told us that further meetings could be arranged to discuss specific topics as they arose.

At our inspection in August 2017 we found a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 regarding the overall governance of the service because of issues regarding staffing, treating people with dignity and respect and lack of stimulation. At this inspection we found these issues had all been addressed by the manager and the provider, and the service was no longer in breach. To enhance day to day management of the service the registered manager organised a daily 'flash meeting' with unit seniors, housekeeper, administrator, a member of the kitchen staff and the maintenance officer. Any issues were brought to this meeting for attention, and action taken to resolve the issues. The registered manager conducted daily 'walkarounds' where they would check the welfare of people, ensure they were appropriately supported and cared for and note any issues regarding the upkeep of the premises.

The provider and registered manager routinely monitored the quality of care provided. Key clinical indicators were monitored, and regular audits undertaken on all aspects of the service, such as a daily medicine audit, to ensure that medicines were properly managed and administered. We looked at a falls audit, which showed that all falls and trips were monitored, and analysis included consideration of people's physical and mental health, the physical environment and the time of day incidents occurred. The area director and area quality director conducted monthly visits, including visits out of hours. Reports from these visits included recommendations and actions and helped formulate an action plan. We looked at the most recent report which showed identified concerns had been addressed in a timely manner.

The registered manager and provider kept up to date with best practice and maintained contact with the local commissioning teams. They attended monthly managers meetings convened by the provider, where they were updated on any new developments in the health and social care field, and also attended the local authority care providers forum. Before our inspection, we checked with the local authority commissioning team and safeguarding team, and they informed us that they did not have any concerns about Oakland and were satisfied with the level of care provided.

It is a legal requirement that each service registered with the CQC displays their current rating. We saw the rating awarded at the last inspection and a summary of the report was on display on the main noticeboard, and displayed on the provider website.