Dorset Healthcare Ltd

Oakdene Nursing Home

Inspection report

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Ratings

Overall rating for this service	Good
Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Overall summary

This unannounced inspection took place on 02, 04 and 22 December 2015. The home is a nursing and residential care home and provides support and personal care for up to 70 older people, some of whom had dementia. The home has two separate buildings within the grounds. One is called Acorn Lodge. Acorn Lodge provides care and support for up to 26 people who have dementia and less physical needs whereas the nursing home provides support for up to 44 people with similar needs but who also have nursing needs. At the time of our inspection there were 67 people using the service, 24 people at Acorn Lodge and 43 people in the nursing home. Both buildings at Oakdene Nursing Home and Acorn Lodge have a ground floor and a first floor which is served by a lift and stairs. There are large landscaped gardens surrounding Oakdene Nursing Home and Acorn Lodge with secure gardens to the south and east of Acorn Lodge.

The home was last inspected on the 10 December 2013 and found not to be meeting the standards in the care and welfare of people and managing records. We found that there were ineffective systems in place to ensure

Summary of findings

people were protected from the risks of skin damage and people's care records did not always contain sufficient information to guide staff on how to meet their needs. These records were not always complete.

At this inspection improvements had been made to the care and welfare of people and in how their records were maintained. Staff told us they visited people in their rooms more frequently to reduce the risk of skin damage and we saw this happen during our inspection. Care records were complete and contained relevant information.

The manager who was a registered manager had been at the service since 2009 and registered in 2012. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

There were enough staff to care for people. We saw sufficient staff available to assist people with their care and support needs and staff were present to help people carry out their activities. Four people and one relative told us that staff were present and available but sometimes took time to respond to people's call bells. One staff member told us that staffing was good across days and nights but that there had been recent staff sickness and leave agreed for staff for other reasons and this meant that existing staff then agency staff were used to fill the gaps. One person said, "The staff get quite busy and I've had to wait for some time for them to respond". Recruitment processes were followed and newly appointed staff were employed only once all the appropriate checks had been made.

People were at reduced risk of abuse and kept safe because staff were aware of how to report abuse and protect people from harm. One staff member told us that physical harm and neglect would be reported to a senior staff member like a nurse or the head of care or social services and would be recorded in the notes. People told us they felt safe living at the home. One person said, "I feel quite safe living here".

People received care from staff that showed an understanding of the risks to people. One person required re-positioning to safely eat their meals. A staff member said, "We carry out regular assessments especially where people may be at greater risk of accidents".

Medicines were managed safely. Medicines were ordered, received, checked, administered and discarded safely. People told us that staff visited them in their rooms when administering their medicines and staff remained with them until they had taken their tablets.

Staff received training, support and had annual development plans. This included moving and handing to support people with managing their posture and movement and safeguarding adults. Nurses had to demonstrate that they had met their professional responsibilities; this is known as re-validation with their professional body.

People were offered nutritious meals and could choose between hot and cold foods. People who needed help with their meals were supported by staff and on occasion by their families. People told us that the food was "good", "tasty" and "you get plenty".

Some people living at the home did not have the mental capacity to make decisions about their care and where they lived. We looked at records and spoke with the local authority to confirm that people had received mental capacity assessments and where necessary Deprivation of Liberty Safeguard (DoLS) authorisations. Some people were still waiting to be assessed for DoLS authorisations due to a backlog of applications by the local authority. The registered manager explained that staff at the home had contacted the local authority to identify people where the arrangements for their care may deprive them of their liberty.

People were cared for by staff that showed empathy and carried out their role with respect for people. In the communal areas we saw staff engaging with people in a relaxed manner.

People received personalised care and support from staff who communicated important changes through shift handover meetings. One person told us that staff respected their choice to remain in bed and in their room. This person had capacity to make this decision.

Improvements were made following learning from incidents. On one occasion someone was at risk of harm

Summary of findings

relating to their posture and newly provided equipment. Since the incident new agency staff were expected to sign a record that they had familiarised themselves with the home's induction process.

The deputy manager explained how complaints were managed through the complaints procedure and these were fully explored and investigated before being addressed.

Quality and safety checks were carried out at the home and actions were taken to improve the standard of care people received. However one system used for monitoring call bell response times were not effective in identifying trends or in producing sufficient detailed information and the management team told us this would be addressed following the inspection.

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?

Good

The service was safe. People received care from sufficient numbers of skilled staff who showed an understanding of the risks to people. Some people felt there was insufficient staff available. Staff told us that staff sickness had led to gaps in the rota however; these were filled by existing staff and agency staff. The rota showed enough staff were booked to cover the shifts required.

Risks were assessed and reported to senior staff once they were identified or where there were changes.

Staff were recruited using all the employment checks required including obtaining references and a full previous employment history.

Staff understood how to identify and report abuse appropriately. They gave examples of how to protect people in their care.

People received their medicines at regular times and in line with their prescribed instructions.

Is the service effective?

Good

The service was effective. Staff received regular training to carry out their duties and responsibilities. They were supported through regular one to one meetings and contributed to their appraisals.

People's consent to care was sought in line with the Mental Capacity Act (MCA) 2005 and staff gave examples of how they checked for consent before care and treatment was offered.

People's health was managed by nurses with support from visiting healthcare professionals including chiropodists, physiotherapists and dentists.

People were given support to manage their meals. There was a choice of hot and cold foods at meal times and snacks were made available between meals.

Is the service caring?

Good

The service was caring. Staff spoke respectfully to people and showed kindness when assisting them. They made people feel valued and promoted positive experiences through thoughtful communication.

Staff engaged people and was seen offering encouragement when helping people make decisions but respected their wishes when these were made known.

People's privacy was maintained when staff delivered care.

Is the service responsive?

Good

The service was responsive. Staff delivered personalised care and support. They encouraged people to participate in day to day decisions when their needs changed and where appropriate.

People received care in line with their assessed needs. Relatives and several people described being involved at their assessments and reviews.

People were approached for their views and suggestions.

Summary of findings

Complaints were investigated and managed. We saw letters complimenting the staff for the care and support people had been given.

Is the service well-led?

Good 

The service was well led. Checks took place to ensure that improvements were made when changes were necessary. One system used for monitoring call bell response times was not effective in producing sufficient detailed information. The management team acknowledged this and explained how this would be changed and addressed following feedback from the inspection.

Care records were kept current and stored securely. Daily notes were made available to staff about people's care.

The management team worked together when changes were made and involved staff in changes through group meetings.

Some people and most relatives knew who the senior staff were and described the management team as having an open door approach. Forums were arranged for people and their relatives to provide feedback and make suggestions.

People, relatives and staff spoke positively about the home and how it was managed.

Oakdene Nursing Home

Detailed findings

Background to this inspection

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

This unannounced inspection was completed by one inspector and took place on the 02, 04 and 22 December 2015.

Before the inspection we reviewed information we held about the service including notifications, safeguarding concerns, accidents and changes the provider had informed the Care Quality Commission (CQC) about. A 'notification' is information that services have to provide to the Care Quality Commission about serious incidents and events and other changes to the service.

We requested a Provider Information Return (PIR) from the service before the inspection and this was returned within the agreed timescale. A PIR is a form that asks the provider to give key information about the service, what it does well and the improvements they plan to make. During the inspection we asked the provider to tell us what they did well and the improvements they planned to make.

We spoke with thirteen people living at the home and five relatives and visitors. We spoke with the registered manager and deputy manager, senior staff, administration and housekeeping staff and six members of the care team. We had contact with two health and social care professionals for their views and who worked in partnership with the service and provided support to people living at the home.

We observed care using the Short Observational Framework for Inspection (SOFI) at meal times and during activities. SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We reviewed three people's care plans, risk assessments and seven Medicine Administration Records (MAR). We looked at daily records about the care people received. These included accidents and incident records, body charts for recording medicinal skin creams and comfort charts. Comfort charts recorded how often people received care including when they were re positioned and offered drinks. We looked at management records including health and safety and service quality checks.

Good

Is the service safe?

Our findings

There were enough staff to care for people. We saw sufficient staff available to help people with their care and support and staff were present to assist people when carrying out their activities. The staff rota showed that the agreed numbers of staff with a variety of skills were booked to cover the shifts and when there were gaps, agency staff were arranged. Recent recruitment had led to newly employed permanent staff. The registered manager explained that they employed staff from a local health and care employment agency they used to request agency staff. Where suitable, there was a contractual agreement with the employment agency that for a fee, agency staff could leave the agency and be employed directly by the provider. Senior staff felt this was one reliable method of recruiting appropriate staff. A staff member told us that although it would be helpful to have more staff their existing levels meant they were able to meet people's needs.

Some people felt that not enough staff was available to respond to call bells. Four people and one relative told us that staff were about but sometimes took time to respond. One person said, "The staff get quite busy and I've had to wait for some time for them to respond". We spoke with the registered manager and deputy manager about this. They told us that staff were assigned to different parts of the home with one staff member available to work between zones to address busy periods or where people needed attention.

One staff member said, "We have a lot of agency staff to cover the night shifts, we struggle to cover these shifts". However, they also told us that staffing was good across days and nights but that there had been recent staff sickness and leave granted to staff for other reasons and this meant that employed staff then agency staff were used to fill the gaps. This was confirmed by another staff member who told us that gaps on the shift had been filled by other staff members. Another staff member said, "There are busy times but even on difficult days the team manage by re-allocating staff between the units".

The registered manager explained that the early and late shift at Acorn Lodge was covered by five health care assistants (HCA), two of whom were senior HCA's and staff worked twelve hour shifts or a shorter shift from 7am till 1pm and a 1pm till 7pm shift. At night there were three HCA's, one of whom was a senior HCA. They also had a twilight shift from 6pm till 10pm four nights a week. At Oakdene, the shift patterns were the same but there were eight HCA's and two nurses for an early shift and seven HCA's and two nurses covered a late shift with senior HCA's available to support junior staff. Night shifts were served by three HCA's and one nurse with a twilight shift of 6pm till 10pm to meet any increase in people's dependency scores. Four activity leaders provided group and individual activities responsive to people's interests within Acorn Lodge and Oakdene nursing home. This included nail care, reading books and newspapers, music and group games.

We looked at the staff rota and saw that sufficient staff were available and people's needs were reviewed. We saw that existing staff and agency staff were used to cover annual leave, training and sickness. Four volunteer staff formed part of the staff team at Acorn Lodge and one volunteer was based in the Oakdene unit. They each received training to support them in their role.

Some staff were supernumerary and had more than one role and were deployed flexibly to meet the changing needs of the service. Where people's needs changed they could be moved between Acorn Lodge and Oakdene Nursing Home to ensure they received the appropriate level of care and support. This showed that people's care was managed flexibly and safely when changes occurred and staff levels were reviewed according to people's needs.

Recruitment processes were followed before newly appointed staff were employed following all the necessary checks. This included requesting references, obtaining a full employment history from applicants and making sure that applicants had not been barred from working with adults and children. Senior staff confirmed that nurses working at the home were fully registered with the nursing and midwifery council before they started work at the home. Three newly recruited staff members told us about their recruitment experience. This included completing an application for the post and attending an interview.

People were protected from harm. People told us that they felt safe living at the home. One person said, "I've been here awhile now, I've made friends and feel safe and I'm happier than when I first arrived". Someone else said, "It's not my own home but the staff make me feel safe and I can talk to them if I get worried about anything". People were at reduced risk of abuse and kept safe because staff were aware of how to report abuse and protect people from harm. For example, staff told us about abuse and how they

reduced risks to people. One staff member told us that physical harm and care neglect would be reported to a senior staff member like a nurse or the head of care and would be recorded in the notes. This staff member described signs of concern or potential abuse and gave an account of how this would be reported and addressed. They told us that managers were on call if concerns had to be reported to social services.

Staff described how they protected people from harm through checking their skin for unexplained marks and from talking to people directly. Body maps were used to capture details about marks and changes to people's skin. We saw several of these including documents from comfort visits which showed that staff were updating information about people's skin care as they visited them. One staff member explained that bruising; marks or changes to someone's usual behaviour would cause concern and be reported. They said, "I know people well and I would notice if their behaviour changed". Several staff gave explanations about how to report concerns if these were not addressed by those in a position to take action. This is sometimes referred to as 'whistle-blowing'.

People received care from staff that showed an understanding of the risks to people and took action to reduce risks. Staff told us about several people who were at risk of falling and of getting lost at the home. These people had alarm mats to help alert staff if the person began to move about their room without assistance and formed part of best interest decisions taken to help protect people from harm.

Individual risk assessments were maintained to keep people safe and included information and guidance about the moving and handling needs of each person. These assessments recorded the equipment and resources staff needed to carry this out safely. For example, moving and handling records gave guidance on the number of staff that was required to help move people and the type of hoist and sling used for individuals. A staff member said, "We carry out regular assessments especially where people may be at greater risk of accidents". One person told us that staff talked to them about their walking when they first came to live at the home. The person said "Staff asked me about my walking as I have had some falls but they still remind me to use my frame" and "The staff come to help me but will often call for extra help when they need to".

Staff explained the risks to individual people they supported, including how one person required positioning to eat their food safely. People had emergency evacuation plans to protect them from harm in the event of a fire and other emergencies. Two people's relatives told us they were kept informed by staff when risks to their family member had changed. One said, "Staff are alert to changes, they let me know and stay in contact; I feel reassured".

Medicines were managed safely. We were shown how medicines were ordered, received, checked, administered and discarded safely. A senior staff member described how medicines were ordered and administered and explained how regular monitoring helped identify gaps or problems that needed addressing. People told us that staff carried out regular medicine administrations. Some people knew about the medicines they were taking and described how staff would stay with them until they had taken their tablets. Medicines including controlled medicines were prescribed, checked, administered and signed for accordingly. Controlled medicines, also known as Controlled Drugs, are medicines that are prescribed for certain serious conditions and include very strong pain relief.

Topical creams and ointments used to manage skin conditions were applied to people's skin. These were administered according to the prescription instructions. Dates showing when these were opened for use were recorded to make sure they were used within their required timescales.

We looked at medicine records including the controlled medicine book and checked that medicines had been administered and recorded correctly. One medicine on one record chart had not been signed and we asked a senior staff member about this. The senior staff member counted the remaining medicines and realised that the dose had been administered but the chart had not been signed. The senior staff member explained that the staff member would be asked to sign the chart when next on duty and they would be reminded of the implications of not signing records. Senior health care assistants were trained to administer medicines to people who were considered needing residential care and nurses administered medicines to people who had nursing needs.

Staff carried out safety checks when administering medicines including staying with people and checking the correct person received the correct medicine. This was

Good

Is the service safe?

confirmed by two people living at the home. One person said, “They stay with me until I’ve had the tablets and they wear that apron when doing the medicines”. Two staff members described the actions they would be expected to take if a medicine error occurred and this included recording the information, seeking help and reporting the incident.

Good

Is the service effective?

Our findings

People received care and support from staff that had the knowledge and communication skills necessary to carry out their work. People and their relatives told us that staff were confident when carrying out their work. One person said, "They all seem very knowledgeable" and someone else said, "The nurses and carers are confident, they know what they are doing". One relative commented, "They are competent and that gives me confidence that they understand what is needed; that makes a big difference".

New staff received an introduction to the service, staff and people living at the home. Staff received regular training and there were processes in place to support staff through regular one to one supervision and appraisals. Staff described the training they received and how they were supported as individuals and as part of their team. One staff member said, "The training is very good, that's why people want to work here". Nursing and care staff followed a training programme and gave examples of their induction and the training they expected to receive.

Nurses had to demonstrate that they had met their professional responsibilities; this is known as re-validation with their professional body. Nursing staff were beginning to consider how they would meet these requirements and this included attending educational events provided by Oakdene Nursing Home. The deputy manager discussed nurse re-validation and had arranged for nursing staff to attend training that could be used to support nurse's re-validation requirements. A senior staff member told us that two training events had been arranged for January 2016. These included diabetic foot care management and supporting people who received anti-coagulation treatment (this is treatment that helps prevent blood from clotting). This was confirmed by several nursing staff.

The deputy manager explained that they attended regular meetings at a national leadership group with health care professionals to discuss research and best practice in skin care, and the prevention of pressure wounds. This showed that staff sought guidance to deliver effective care and improve standards.

Records showed that staff received regular training, support and appraisal. Four care staff had begun working towards their care certificates. These care certificates have replaced the social care induction programme.

Some people did not have the mental capacity to make certain decisions about their care or where they lived. Staff were aware of the Mental Capacity Act 2005 (MCA) and how this affected people's care. The MCA provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

Staff at the home worked within the principles of the MCA. The manager told us they had assessed the mental capacity of people living at the home and this was regularly reviewed along with other assessments related to people's care. One person told us that staff approached them first before they started caring for them and we saw staff use opportunities to talk to people and check their consent with them before administering Care.

Some people had safety alarm mats and protective bed rails to prevent them from coming to harm. In these cases people had best interest decisions. These decisions were made in discussion with families and staff and provided the least restrictive measures available to balance people's right to safety while restricting their movements which could lead to harm.

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 contacted the authority responsible for the Deprivation of Liberty Safeguard authorisations before the inspection. They told us that they had received requests for DoLS authorisations for people living at the home. Some people were waiting to be assessed by staff in the authorisation department, while others had been assessed. We asked the manager whether any conditions on authorisations to deprive a person of their liberty were being met. The manager told us about several people that had a DoLS authorisation and was aware that these were time limited and would require review but there were no other conditions.

People were provided with sufficient food to eat and a choice of drinks. People told us that the food was very

Good

Is the service effective?

good. One comment included "Its good food, not like home cooking but very tasty". Someone else said, "There's plenty for everyone if you want more you just ask and they often offer extra". Meals were served in communal areas and we watched staff provide support and assistance where appropriate. People told us the meals were hot enough and they had scope to choose what they wanted each day. One person told us that if they changed their mind staff would suggest alternatives. Some relatives visited at meal times to assist their family members. One person told us they were made welcome by staff and felt involved in the social aspect of their family members care. During one lunch time we observed staff and people enjoying the meal experience and sharing social humour. People were laughing and responsive to staff throughout the activity.

People could choose from two deserts and fruit if they preferred. People had cold and hot drinks with their meals and throughout the day. People who spent time in their room had drinks available to them. One person was not able to reach their drink and staff told us that this person was not safe to drink independently and was offered drinks during comfort visits.

Some people were served their meals in their rooms either from preference or because they were not well enough to join others. Meals were regular and snacks and refreshments were offered in the morning and afternoon. Where people did not like what was offered they could choose sandwiches or an alternative meal. Some people required an increase in their daily calories and were encouraged to have fortified foods. Several people had swallow plans which gave guidance to staff on how people needed posture support during and after their meals. These plans were based on assessments by Speech and Language Therapists and were discussed with staff and families. One person needed assistance to eat their food and staff encouraged them to enjoy their meal without rushing.

Records showed that where people were at risk of losing weight their meals and weight was monitored to ensure they maintained their calorific intake.

People's health was monitored and they were supported to maintain their health through the help of visiting health professionals. A healthcare professional said that people were quickly referred for foot health where people had requested this or where there was an urgent need. They commented that people were well cared for and referrals were made in a timely way. Records showed that people saw a range of health and social care professionals on a regular basis to maintain their mobility, manage medical conditions and meet their dietary needs. People told us they had health and medical appointments and these were often arranged by the staff and or their families. One person said, "There was a choice when I came here – there are local doctors, dentists and opticians when you need them". A staff member told us that a visiting optician came to the home to make it easier for people to have their vision reviewed. This meant people's health needs were met because staff took action to refer people as their condition changed.

Good

Is the service caring?

Our findings

People were cared for by staff that demonstrated empathy and carried out their role with respect for people. In the communal areas of Acorn Lodge and Oakdene Nursing Home staff engaged with people in a relaxed manner. Staff created a positive and happy environment and encouraged people to enjoy their activities. At lunch time one staff member made people laugh when sharing light hearted but appropriate banter. Staff talked to people in a polite and respectful but approachable manner. Staff understood people's needs and preferences and spent time talking with people when they visited them in their rooms and communal spaces.

People told us their relatives were invited to parties and special occasions at the home and visiting was not restricted. Two relatives and two visitors confirmed this and one person's relative told us they visited daily to help with meals and this was respected by the staff. They said, "Staff know I visit each day, they give very good care here; I have no concerns about the quality of care my (person's name) receives". We heard staff address people by using their names. Staff also knew the informal names people had chosen to be addressed by and used these appropriately.

People developed positive and caring relationships with staff. Relatives told us that staff were caring. One relative told us that staff kept them informed of changes in their family member's condition. Another relative visiting Acorn Lodge said, "Everyone's so kind and they (staff) spend time with people" and "The staff are very warm and welcoming; they have a good relationship with people here". One relative told us that staff were friendly and considerate when carrying out people's care. One person told us that when they first arrived at the home they felt lonely but staff took an interest in them and helped them to settle. This person said, "At first I didn't like to trouble the staff but they listen if you have a problem, which really helped".

We spoke with several staff who gave clear descriptions about people's preferences and their individual choices. For example, two people preferred to spend more time in their own room and staff understood and respected this. One person had made decisions about how they wanted their room arranged so that it was similar to their previous bedroom at home. Several staff explained that's people had rights to make choices and decisions for themselves and that this was encouraged by all staff following training and greater awareness of personalised care.

People were encouraged to share their views. One staff member described how one person had made clear their wishes to remain independent. The staff member explained how important this was for the person and that staff were made aware of this. Equipment was made available for several people to assist with their movement. We heard staff encouraging people to contribute to decisions about their needs. One staff member discussed the assistance that someone needed. The person expressed how they had lost confidence in walking and the staff member suggested a second staff member to assist.

People and their families were involved in discussions about their end of life care wishes and these were documented in their notes. One relative told us that senior staff had approached the subject with sensitivity and had explained 'advanced care' needs. Advanced care helps staff and families plan and prepare for when someone becomes very sick and may not be expected to recover. The relative also explained that staff sought information about people's faith and how they wished to be cared for, if they became very ill. This formed part of the assessment when people came to live at the home. The home is registered with the Gold Standard Framework for end of life care. The Gold Standard Framework is a standard of care that people can expect when they are near the end of their lives. It is designed to meet the physical, spiritual and emotional needs of people who are dying, with a focus on the management of symptoms, comfort, dignity, and respect. Skilled staff had been trained to provide care and support to people who were nearing the end of their lives. These staff could be easily identified through a small yellow flower they wore on their uniforms. This meant they could be called upon to spend time with people and to support their individual needs. A recent presentation had taken place to highlight the Gold Standard Framework and this included staff, people and visitors who were all invited to attend and join in with the educational and social event.

Staff promoted people's dignity and respected their privacy. Doors were closed when care was provided and staff knocked before entering people's rooms. While some staff waited for a response other staff did not because

Good

Is the service caring?

some people had difficulty hearing and staff were aware of the challenges for these people. One person joined a social activity and staff made sure that the person's catheter bag was discreetly concealed.

On occasions we saw the word 'Zimmer frame' written in people's care records and heard staff use this term to describe people's mobility. We drew this to the attention of the deputy manager who discussed the possible alternatives that could be used. They explained that this would be shared with the wider team.

Good

Is the service responsive?

Our findings

In the previous inspection in December 2013 we found that the home did not have effective systems in place to ensure people were protected from the risks of skin damage.

At this inspection we found improvements had been made. The home had introduced more frequent checks for people who were at risk of developing pressure wounds. These checks were known as 'comfort' visits. The purpose of this was to ensure that people were not at risk of pressure wounds developing. These 'comfort' visits meant that staff carried out checks on people's personal care, skin management, posture changes and drinks for people and to ensure that people who could not independently meet their own needs were kept comfortable. These checks enabled staff to review people's posture, comfort and personal care needs. Visits were recorded on charts which were kept in people's rooms. We spoke with staff and looked at five records which showed how staff had recorded their findings and the care they had given.

People received personalised care and support from staff who communicated important changes at shift handover meetings. One staff member who had worked at the service for only a few weeks was well informed of several people's personal care needs. Another staff member who had worked at the service for only a few months gave detailed descriptions of people's social needs. They told us how they had persuaded and assisted one person to leave their room and join a social activity. One person had been encouraged to take a visit out in the community with other people at the home. This person had not previously left their room and as a result of the social event had made friends with another person at the home. One person told us that staff respected their choice to remain in bed and in their room. This person was able to make the informed decision and staff had offered more contact with activities in their room. Activity leaders involved people in singing and music sessions, newspaper readings followed by discussions, group floor games and date and year specific reminiscent sessions. One person who did not leave their room very often had been supported with enhancing their room with themes of interest.

One person received assistance to move between their room and the communal area. The staff member asked the person how well they were feeling and whether they wanted to join in with the planned activity or return to their room.

For some people who found it difficult to make some decisions about their care, staff involved their relatives directly. Two relatives gave examples of how staff had discussed the changing needs of their family members. One example related to posture and more appropriate seating and another related to changes to the person's food plan which had helped the person retain their weight.

A staff member described how they had approached someone's family member to learn more about the person's previous hobbies and interests. The staff then used this information to tailor individual activities in one to one sessions with them when it was difficult for the person to join others. Assessments on what equipment was necessary for people to stay independent were recorded in their care plans. When people were taken to hospital for treatment a care record accompanied them to inform hospital staff about important information. This meant that people could receive similar care when they were not living at the home and NHS staff were aware of people's individual needs.

Assessment and care plans were written in a personalized style and referred to the person by name. Detailed information gathered directly from people and or their families presented an informed perspective of the person, their life, their preferences and their previous history. These were known as 'This is me'. These and other records were signed by people and in some cases when this was not possible, by their families. People had information on their doors and in their rooms to highlight previous special events. Photographic moments were captured to help people reminisce on important times in their lives. People had a choice about how they practiced their faith and their beliefs were recorded in their plans while religious services were offered within the home on a regular basis.

People's experiences and concerns were explored and investigated. The deputy manager described three complaints received by the home over the previous six months and explained how these were managed. We saw letters of compliments received which acknowledged the support people had been offered. Letters of thanks and appreciation were shared with the staff.

Good

Is the service well-led?

Our findings

In our previous inspection in December 2013 we found that people's care records did not always contain sufficient information to guide staff on how to meet their needs and these records were not always complete.

At this inspection improvements had been made. Care plans and other records were completed in detail. Daily records of people's personal care were informative and effectively maintained. Care plans were comprehensive and these had been regularly reviewed and updated. For example, one record documented medicine changes for one person and contact with a range of healthcare professionals along with the outcome of their visits.

Some people expressed concern about the response time to calls bells. Although this was monitored, the system was not as effective as it could have been at capturing the level of detail sufficient to provide reliable data and lead to positive change. For example, the system used to record call bell response times could not give accurate response times across several dates and had not captured the information required to monitor the system effectively. This meant that staff could not be sure how long some people had waited for support. We asked the deputy manager about this. They acknowledged these points and agreed to review how this was gathered. The registered manager and deputy manager explained that the system used to collect this information would be re-programmed so that response times were recorded more frequently. They explained that this would show when call bell alarms were raised, when they were de-activated and how long staff had spent with individuals, meaning that more useful information was collected and gathered to monitor the quality of the service.

Accidents and incidents were monitored monthly. We asked how risks from incidents and accidents were identified to ensure that people were not left at unnecessary risk in between monthly monitoring. The deputy manager explained that entries in the accident book were reviewed weekly and risks associated with pressure wounds and infection control formed part of daily care records which were reported on and reviewed by the head of care. Monitoring was used to identify a range of factors including cause, time of incidents/accidents, the level of injury and whether the accident had been witnessed. This information was used to identify patterns in incidents so that responses could be considered.

A variety of checks including clinical audits (known as quality monitoring checks), were carried out on equipment, care plans, records, infection control, skin care management, medicines and facilities at the home to good effect. Maintenance of the building, fire equipment and other resources were checked on a regular basis. This showed that where most checks were carried out, the results were used to maintain the quality of care at Oakdene Nursing Home.

Improvements were made where incidents had happened. Staff used the learning from these to improve practice and make appropriate changes. These events were discussed at staff meetings and supervision sessions. The registered manager explained that following a notification involving a serious incident they had made changes to information made available to agency staff. For example, on one occasion someone was at risk of harm related to their posture and the use of newly provided equipment. Since the incident, agency staff were expected to sign a record that they had familiarised themselves with the home's induction plan so that they understood what actions they needed to take in certain situations. This showed that the organisation was pro-active in learning from events. Laundry care had also been reviewed and changes made had led to improvements for people.

There was effective leadership at the home. People and relatives felt the home was well managed. Most knew who the registered manager was and how to reach them. One relative said, "The manager is accessible if you need to speak with them and there is always someone in charge". The registered manager told us that there was an on-call system so that staff always had contact with an experienced member of the leadership team. During the inspection the provider was available and spent time at the home. They contributed to the inspection process and provided support to senior staff.

There was a shared understanding about the challenges, difficulties, progress and achievements taking place at the home. For example, all staff had been involved in promoting the Gold Standard Framework for end of life care. An event had been arranged for staff, people and relatives who came together to share and develop their

Good

Is the service well-led?

ideas. Staff at all levels felt the culture of the home was positive and progressive. One staff member said, "There is a very good management structure here". Another staff member described how team meetings enabled staff to contribute through their ideas and suggestions. One staff member said, "You can speak with one of the managers at any time and the main manager has dedicated time each week to speak with staff if needed".

Staff, people and relatives at Acorn House spoke about the open and friendly culture. Comments included "It feels like home even though it's not your own home" and "It's like an extended family". One staff member described it as the best home they had worked in. Forums were arranged for people and their relatives to provide feedback and make suggestions. People and their relatives had the opportunity to respond to questions about themes at the service. These included the quality of the food, type of activities, trips into the community, personal choices and how people contributed to their care.

The home had a registered manager and a deputy manager. The provider was also present throughout the inspection and contributed to the inspection process. Most people and their relatives knew who took responsibility for the management of the home and complimented staff and managers for their work and leadership. Staff told us that the registered manager offered dedicated time to speak with staff and had an open approach to problem-solving. Staff were confident that some of their suggestions would be listened to and where possible changes would be made. Staff spoke confidently in the way the home was led and felt involved and engaged in changes through discussions at group meetings.

Services registered with the CQC have to send notification of certain events as part of their responsibilities. Registration requirements, including statutory notifications were received by the CQC in line with the appropriate processes. The service had a Statement of Purpose which set out how the service aimed to provide high quality personal and nursing care.