Kingsley Care Homes Limited

Four Oaks Care Home

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

The inspection took place on 2 and 3 August 2018 and was unannounced. The first day of the inspection was carried out by two inspectors, a pharmacy medicines 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. The expert had personal experience of services for people living with dementia. Two inspectors and an assistant inspector returned for the second day.

The last inspection of this service was on 7 and 8 December 2017 where we found breaches in six regulations of the Health and Social Care Act 2008, including concerns that placed people at serious risk of harm. These were in relation to service user safety, falls prevention, mitigating known risks, training of staff, medication, staffing levels and shift management, the monitoring of fluids and the governance and leadership at all levels. Following the inspection, we asked the service to take some immediate action and told the home to produce an action plan to address the issues we had found. We returned to Four Oaks on 19 January 2018 to check that these actions had been taken and the action plan was being implemented.

At the last inspection, we rated the service overall inadequate and the service has been in Special Measures. Services that are in Special Measures are kept under review and inspected again within six months. We expect services to make significant improvements within this time frame. During this inspection the service demonstrated to us that improvements have made and is no longer rated as inadequate overall or in any key questions. Therefore, this service is now out of Special Measures.

At this inspection, we found significant improvements had been made for the safety and welfare of people living at the home. Further details can be found throughout the body of the report.

Four Oaks 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. Four Oaks is a modern purpose-built property which can accommodate up to 62 people in four separate units on two levels. Two units specialise in providing care for people living with dementia. At the time of our inspection there were 59 people living at Four Oaks.

A registered manager was in place. 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.

A new computerised care planning system, person centred system (PCS) had been implanted throughout the home which had largely improved the care planning of each person living at the home. The system was easy to use and staff could record onto the system in real time which had improved daily recording for people. Staff also had access to people's care and support needs quickly and the system gave prompts to

staff to ensure they had completed each task required.

Everyone living at the home said they felt safe. People told us if they had concerns about their safety, then they would have no hesitation is telling someone. Staff we spoke with were aware of their responsibilities in reporting any concerns they had and had completed safeguarding training to enhance their knowledge.

Staffing levels across the home had improved and staff were visible throughout our inspection. All staff we spoke with said there was enough staff on duty. We received mixed responses from people living at the home and relatives with comments being that the home was short staffed at weekends. Agency staff were still used and rotas showed that staffing levels remained consistent across the week. The staff from the agency were regular for consistency.

Staff were recruited safely and received the required checks before employment commenced to ensure they were suitable to work with vulnerable groups.

The management of falls has significantly improved and people who were at high risk of falls were regularly monitored and had appropriate equipment such as falls sensors and mats in place. Staff had received training in falls management and regular reviews of falls looked for themes and patterns with actions identified to assist in preventing future occurrences.

People at risk of choking were regularly assessed and protocols were in place to give advice to staff on suitable consistencies of food and fluids. Staff could clearly describe food and fluid consistency for each person they supported.

People whose behaviour may challenge were risk assessed and some good techniques to reduce agitation were recorded for staff to use. Staff had received training in managing challenging behaviour.

Accidents and incidents were clearly recorded and outcomes shared to prevent future occurrences. Each person had been assessed to ensure they could reach and use their call bell. For those who could not, additional room checks were made to ensure peoples safety.

Medicines were well managed and staff had been appropriately trained to administer medication safely. Improvements had been made to the safe administration of medicines to ensure people who wished to stay in bed, could have their medication at a later time without having to miss any doses. Medicines were regular audited to ensure the safe administration and all medicines were stored securely.

People received an assessment of their needs prior to moving into the home. The assessment then was used to generate care plans using the PCS system. Care plans were generally completed within one to three days of the person moving into the home and where possible, care plans from previous care providers were used while staff got to know the person.

Improvements were needed to enhance people's dining experience. Although people had choice around meals, they were not planned in advance. Lunch was late on the first date of inspection and items were missed on the food trolley which meant people did not have the item with their meal.

Staff were able to record on the PCS system what people had to eat and drink and hydration checklists were in place to ensure people had at least six to eight glasses of fluids per day. People had clearly recorded in their care plans, their likes and dislikes and their dietary requirements. One person preferred a diet from their own culture and this was observed. The chef met with people to discuss their dietary needs and had

details of people's preferences and requirements including any allergies.

Staff received training to enable them to carry out their job role effectively. The service was in the process of registering with a training consortium to be able to engage in standardised training across the local authority. Additionally, the organisation was working with a training provider to provide diplomas in health and social care. This meant staff could receive training to enhance their knowledge and their role.

The service was working in line with the Mental Capacity Act 2005. People who had their liberty deprived, did so in their best interests. Families were involved in making decisions for their relative and we saw some good examples of best interest's decisions being taken.

People received appropriate referral and support from health professionals. People told us that they could see a GP when they needed to and we saw that where concerns had been identified in people's health and wellbeing, referrals were made in a timely manner.

We observed kind and caring interactions from staff to people who lived at the home. We spoke with a relative who had concerns about the home at the last inspection and whom now spoke highly of the service.

People were given choice to how they spent their day and staff were able to describe how best to support each person. Staff told us how they observed people's dignity and we observed staff to knock on people's doors and ask for permission to enter. Staff told us that they always explained what they were doing when assisting people with personal care and people told us that staff sought consent from them.

Care planning for people had significantly improved with the implementation of the PCS system. Care plans were person centred, had involved people and captured people's support needs and preferences. Staff had access to people's care plans at the touch of the button using the PCS iPod system which meant staff could continually access and update information.

People received support at the end of life and we saw that people could be supported to stay at home at the end of life if that was their preference. People and their families were included in end of life planning and staff were clear on what people's preferences were.

Complaints were responded to in a timely manner. Outcomes of the complaints we viewed were factually correct and shared with the complainants with actions learned from the complaint.

The registered manager had complete oversight of the service. We observed that they conducted daily walk around of the service and had a team of support working alongside them to continue to monitor and improve the home.

Staff felt well supported by the registered manager, deputy manager, clinical lead and nurses. Relatives we spoke with felt the registered manger had largely contributed to the improvements within the home.

Audits were in place and regularly reviewed to monitor and improve the service. Clear action plans were in place to highlight where improvements were needed and the actions to be taken.

The service had worked closely with the local authority to improve the service and they acknowledged the work the service had undertaken to improve the home since the last inspection

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 is safe.

There have been significant improvements in the management of falls and processes put into place to risk assess, assist in the prevention and monitor people who are at high risk of falls.

Staffing ratios had significantly improved and we observed staff to be available on each unit at all times.

People at risk of choking had been appropriately assessed and staff had received training to manage risks. Clear protocols were in place to support people who required fluid thickeners for staff to follow.

Is the service effective?

Requires Improvement

The service is not always effective.

Further work was required to improve the dining experience at the home.

Fluid and food intake was clearly recorded and additional staff members were available to support people to eat and drink.

Training had improved across the home and training in falls and nutrition had improved. The service was in the process of joining a training consortium to enable them to access further training across the local authority.

Is the service caring?

Good

The service is caring.

We saw kind and dignified interactions between staff and people living at the home. Staff had the time to spend with people and people felt cared for.

Relatives who in the last inspection had been concerned about the care at the home, now found the staff to be supportive and caring and the service had improved very well.

People were referred to in their preferred name. People had choice of where they preferred to spend their day and if they joined in activities.

Is the service responsive?

Good

The service is responsive.

Care planning displayed accurately the care and support needed to keep people safe and well. The implementation of the person centred system had aided staff to have access to information to support people promptly and complete care records in real time.

Activities were more widely promoted within the home. Staff had received training from an external activities training service and staff were more involved with engaging people in activities.

Complaints were acknowledged and investigated in a timely manner with outcomes shared. Responses to complaints were factually correct and where required, the service had applied the duty of candour.

Is the service well-led?

Good

The service is well led.

People, relatives and the staff team were complimentary of the registered the manager and the steps taken to improve the home.

The registered manager and senior managers and directors had oversight of the service. We observed management knew people and their families well and were responsive to the staff team.

Audits were in place to monitor and improve the service. A computerised system was in place to assist with audits and assisted in the production of an action plan when an audit did not meet expectations.

Four Oaks Care Home

Detailed findings

Background to this inspection

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

The inspection took place on 2 and 3 August 2018 and was unannounced. The first day of the inspection was carried out by two inspectors, a pharmacy 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. The expert had personal experience of services for people living with dementia. Two inspectors and an assistant inspector returned for the second day.

We reviewed information that we held about the service including previous inspection reports and notifications. A notification is information about important events which the service is required to send us by law. We also obtained feedback from the local authority regarding the progress of the home since the last inspection. Further details can be found in the body of the report.

We asked the provider to complete a PIR. The PIR is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make

During the inspection we observed interactions between staff and people who used the service. As some people were not able to tell us about their experiences, we used the Short Observational Framework for Inspection (SOFI) during the lunch period and in the lounge areas of the home. SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us. We spoke with eight people who used the service, eight relatives, the registered manager, the quality manager, 11 care staff, two senior carers, two nurses and the cook. We observed the way people were supported in communal areas and looked at records relating to the service. These included 12 care records, five staff recruitment files, daily record notes, 15 people's medication administration records (MAR), maintenance records, accident and incident records and quality assurance records

Good

Is the service safe?

Our findings

At our last inspection of Four Oaks Care Home in December 2017, we found there were three breaches to Regulation 12 of the Health and Social Care Act Regulated Activities (Regulations 2014) as the provider had not taken reasonable practicable steps to mitigate risks to the health and safety of people living at the home. People were at an increased risk of choking as the care staff did not have clear information available to them about the consistency of fluids each person required. There was a lack of 'as required' medicine protocols, concerns around the time taken to administer morning medicines and there were missed dosages of medicines and a lack of body maps for creams.

At this inspection, we found that significant improvements had been made to mitigate risks to people living at the home. People at risk of choking were assessed and staff could clearly explain how each person at risk were supported to eat and drink. As required medicines were clearly identified and gave detailed information on when they maybe required. Body maps were in place to highlight where people required prescribed creams to be applied and there had been no missed dosages of medicines identified.

We highlighted at our last inspection, where people were at high risks of falls, risk assessments were not robust enough to mitigate those risks and give guidance to assist in preventing falls. At this inspection, we found that each person had received an in-depth risk assessment and where people were at high risk of falls, falls sensors and mats were used to monitor people who maybe mobile without supervision and regular checks were made and recorded to ensure people were safe.

A 48-hour post monitoring check was completed to check on the person's recovery after an incident. This looked at the persons equipment such as a low bed, was the nurse alarm in easy reach, was the person's chair appropriate for their height and was the person walking space clutter free. A multifactorial falls risk assessment was implemented within 24 hours of a fall which was used to assist in identifying the risk factors for people falling. Additionally, the risk assessment looked at medical risk factors, lighting, falls history and how a person mobilised.

The registered manager completed a falls analysis every month, this was to look at any emerging patterns or trends. The number of falls occurring had fallen greatly since the last inspection and chair sensors were visible on all arm chairs. This meant the service was being proactive in managing falls.

The service had introduced a computerised recording system, person centred system (PCS) and all risk assessments were detailed on the handheld iPod which staff carried around with them. This gave staff immediate access to information about each person they supported and could be updated instantly. We saw that in the risk assessment section of the system, people had recorded information relating to mobility, pressure area care and nutrition. Each assessment was reviewed every 28 days as the system highlighted when the review was due. The assessments also included guidance for staff to ensure they used the correct equipment for moving and handling or where people required a soft or blended diet. This meant that appropriate risk assessments were in place and were regularly reviewed to keep people safe.

People whose behaviour may escalate had behavioural care plans in place on the PCS system. The care plans detailed triggers and distraction techniques for staff to use to de-escalate potential behaviours from occurring. We saw for one person who used to work in an office, where behaviours were escalating, the staff would give them paperwork to file which would distract them from their anxiety.

Previously we found that the medicines rounds took so long that people had to miss doses of their medicines because the time interval between doses was unsafe. Improvements had been made in the timing of the medicines rounds and people were able to have their medicines at the times they needed them. Some people chose to get up late and we saw that they did not miss doses of their medicines.

Systems were in place to record when medicines which need to have a minimum interval between doses, such as paracetamol, were given. However, the system did not allow staff record the time it was given when it was administered regularly three or four times daily. This meant that people were at risk of having their does too close together. This was actioned on day two of our inspection and we saw that times were being recorded.

Some medicines needed to be given at specific times with regards to food and we saw that with the exception of one medicine all these medicines were administered safely. The medicine not being given time specifically was rectified the same day.

Protocols had now been put in place to guide staff to administer medicines which were prescribed "when required". These protocols are very important in ensuring people get these medicines consistently and at the correct time, especially if they are unable to communicate their needs verbally. We recommend that the provider clarifies where more than one medicine is used to treat the same condition, which medicine should be used first and this is recorded in the protocol.

Previously when people were prescribed food and fluid thickeners to prevent them from choking there was no information available for care staff to refer to when making drinks. We saw that there was now information on the PCS system and there was a paper "brew list" on the kitchen cupboard which detailed how people liked their hot drinks and if they needed to be thickened. Staff were able to describe who required what consistency of fluids. This meant that people using food and fluid thickeners were being supported to do so, safely.

Medicines were stored safely in air-conditioned rooms and those that required cold storage were stored in dedicated medicines fridges. The temperatures of the rooms and fridges were monitored which meant that medicines had been stored properly and were safe to use.

We saw some creams were stored safely in people's bedrooms. One person had their tube of E45 emollient cream in the bathroom on the same shelf as their toothbrush and toothpaste. The person in the bedroom did understand the difference in the products but we advised the provider to assess the safety of people having creams in their rooms and provide a suitable safe place for storage.

We saw some examples of good medicines management for instance when people needed to have their medicines given covertly, by hiding it in food or drinks all the relevant permissions were in place and there was information on each medicine given from the pharmacist as to how to hide medicines without reducing their effectiveness. When medicines were withheld for any reason an explanation was recorded. The system for checking stock worked well and showed that medicines were given as prescribed and that they could be accounted for.

People and relatives, we spoke with said they felt safe living at the home. Comments included; "I'm just safe, I've no worries, this place is very, very good"; "There's a lot of people around and you can lock the door"; "I feel safe, its secure." Relatives told us, "Yes, he's safe he can't get out and if he has a fall they let me know"; "He's not falling as much now, they have put things into place to manage it."

People were kept safe and protected from abuse. Another relative told us that they would not have any issue in raising concerns with the registered manager. The service had safeguarding policies and procedures for managers and staff to follow if required. All the staff we spoke with could describe what action to take if they suspected abuse was occurring and each staff member said they had full confidence the registered manager would act on their concerns. A whistle blowing policy was also in place and each staff member we spoke with confirmed they knew why the policy was in place. All staff members we spoke with told us they had received training to give them an understanding of abuse and knew what to do to make sure people using the service were protected. We also saw training certificates confirming training had taken place.

We reviewed five staff personnel files and all had the required pre-employment checks in place including two written references and a Disclosure and Barring Service (DBS) check. This meant that the service had followed the processes in place to protect people from receiving care from staff who were unsuitable. A profile of agency staff was kept which included ensuring they had received a DBS check and references and appropriate training to enable them to carry out their role.

We found staffing levels were consistently reviewed using a dependency tool and all staff we spoke with said there had been good improvements to staffing levels. People told us, "There are enough staff, they pop their heads round the door and ask if I'm okay"; "There's mostly enough, unless someone goes off sick and they usually ring for somebody else"; "They get short of staff, but they're very good and they get agency and its staff we know." Relatives told us, "They are not always [fully staffed] at weekends and can be a bit short. They do get agency, but they don't know the residents"; "Weekends are the worst, staff just don't turn up or give short notice. Nursing staff are very good, it's the caring staff" "As she needs two to move, she has to wait to use the toilet." We discussed this with the registered manager who told us that they had identified where sickness levels were high and were working to recruit a bank team of staff. We saw on the rota that regular agency staff were used and checked that staff signing in records reflected what the rota displayed. We also viewed the staffing levels at the weekend which showed the same numbers of staffing levels that were reflected in the week.

Our observations on both days of inspection were that there were enough staff available to support people's assessed needs. Staff told us they generally worked on the same unit for continuity with one staff saying they occasionally moved to cover but this was to ensure the correct skill mix of staff. Two staff we spoke with said on one unit, sometimes they could be stretched, however, two further staff from the same unit said staffing levels were fine and they managed well.

We saw an analysis of the accidents and incidents and any outcomes were documented and learning from such concerns were shared with staff members. We saw that body maps were in place which identified where any injuries had been sustained. Incident reports were completed via the PCS system. This meant the service was proactively working to reduce the frequency of accidents or incidents from reoccurring and looked at themes and patterns emerging.

Nurses and senior staff did regular checks of the call bells to ensure they remained plugged in. A list of people was displayed in each office showing who could use the call bell and those who couldn't were given extra room checks to ensure their safety.

We checked the systems in place to protect people in the event of an emergency. We found that personal emergency evacuation plans (PEEPs) were in place for all people who used the service and a copy was kept in the reception area. This meant information was available for the emergency services in the event of the building needing to be evacuated. Fire drills were regularly carried out to check that staff understood and were familiar with the operation of the emergency fire action plan.

We saw all equipment had been serviced according to the manufacturer's instructions. There were weekly internal checks of the fire alarm system, emergency lighting, nurse call alarm and water temperatures. We viewed servicing certificates which were in date for gas, fire alarms, emergency lighting, electrical installation, portable electrical equipment (PAT) and hoist. The service had appointed an external organisation to manage the passenger lift. There were documents in place confirming that the lift had been serviced at regular intervals. A fire risk assessment and legionnaires risk assessment was in place.

We noted that kitchen within each unit had been fitted with a key pad mechanism which relatives knew the access code if they were locked and could go in to make a drink. Also, items such as kettles and microwaves were removed when staff were not constantly monitoring the area.

We observed staff using personal protective equipment (PPE) such as gloves for use when delivering personal care. We also saw that PPE was readily available within the home. We saw that the service had an infection control policy in place and staff confirmed to us that they were aware of the requirements of the policy. We saw certificates confirming staff members had received training in infection control.

Cleaning records were completed daily and we saw records relating to monthly checks of mattresses and cushions. We found the service to be clean throughout and were assured that the service was taking necessary action to prevent the spread of infection.

Requires Improvement

Is the service effective?

Our findings

At our last inspection of Four Oaks Care Home in December 2017, we found breaches to Regulations 9, 14 and 18 of the Health and Social Care Act Regulated Activities (Regulations 2014) as the provider had not written initial care plans in a timely manner. There was a lack of support for people to eat and in complete fluid charts. There was a lack of sufficient staff and staff training was not up to date and staff did not have the skills to meet people's needs.

At this inspection, we found care plans were generated from the pre-admission assessment in a timely manner. Staffing levels had increased to enable more support for people to eat and drink and fluid intake was clearly recorded on the person-centred system (PCS). Staff training was up to date and complete and the provider had sourced further training from other resources.

Pre-admission assessments were completed by the deputy manager or the nurse. The care plans were formulated on the PCS as the staff got to know the person. We saw were people had transferred from another care environment, the service requested copies of their previous care plans to be available for staff to read. There were no time frames for the care plans to be written by and for three new admissions, care plans had been completed within one day while for another person, none had been completed by their third day, however, there were care plans available from their previous placement. The service at the time of inspection was employing care co-ordinators to be trained to complete care plans and administer medicines to allow the nurses more time for clinical procedures. We will review this at our next inspection.

We observed a verbal handover to staff about people's needs and they could read the care plans and the planned care on the iPods they carried with them. Staff said they had enough information about people's needs when they moved in. The staff on each unit could describe the needs of someone who had just moved in to the home. Their relative who was very positive about the move to the home said the staff had all been keen to get to know their mum and had spoken with the relative about her, they also told us, "The staff have been very welcoming. I'm very happy with the level of care for mum."

The mealtimes we observed were relaxed but required more organisation, staff were sat at the table supporting people and others were having friendly conversations with each other over the dining table. People received help, support and encouragement they required to eat and drink when needed, however we observed some items displayed on the menu board were missing and a quiche that was sent up was missed in the trolley as it was not listed on the menu board. At the time of inspection, the chef was planning the meals the day before as the kitchen had been short of staff but the aim is to have a four-weekly menu in place and we saw plans of the menu being put together. Staff were contacting the kitchen daily to be informed what was on the menu and recording this on the menu board. Staff told us that was not uncommon although they said food had improved and there were more salads, fruit and snacks readily available. Each person had a hydration checklist kept on each unit where everybody was to aim for six to eight glasses of fluids a day which was then recorded on the PCS. People who required their fluid intake monitoring had this clearly recorded on the PCS system.

People told us. "It's [the food] not too bad, I quite like it. If you want anything different the chef will do it. I had poached eggs for lunch and some days I have yellow fish" "I don't have any problems, food is great, there's two choices but they would cook me anything I asked for" It's alright, I enjoy it sometimes. You can have what you want" "I suppose it's good, but you get fed up with the repetition."

Relatives told us, "Lunch is quite often very late, and on Saturday they have a cooked breakfast, then for lunch they have left over beans, bacon and an omelette. We are supposed to be getting menus"; "The soft food is the same every day. If they presented it better it would help". On the first day of inspection, lunch was ready by 13.30.

We visited the kitchen and saw there was a file which listed people's dietary requirements including likes, dislikes and allergies. The chef was able to describe the types of meals people eat and was aware of a person who required a halal diet. The chef told us when a new person came into the home, they would chat to them to find out their dietary requirements or speak to staff if the person was unable to communicate. We saw that cereals and fresh fruit were available at breakfast and a cooked breakfast was made to order.

Care plans on the PCS gave information on people's specific diets, type of diets and if they ate independently. We saw people being encouraged to eat a healthy diet and those at risk of malnutrition ate a fortified diet. This was under the advice of a dietician or other health professional. Each staff member we spoke with were aware what type of diet each person had such as soft or fork mashable. We also saw that people's food and fluid intake and weights were regularly monitored and recorded on the PCS system. When people were identified of being at risk of malnutrition and weight loss was a concern, we saw appropriate referrals were made to the dietician.

The staff files we viewed showed that staff received an induction into the service and staff members confirmed this. We saw induction included mandatory training and the opportunity to shadow more experienced staff members. The training was completed away from the service and included reviewing the policies of the organisation

Staff we spoke with said that they were kept up to date with training and had completed a lot of training over the last six months. Staff received training which included moving and handling, safeguarding, deprivation of liberty safeguards, mental capacity, nutrition and food thickeners, continence, medication, fire safety, dementia and first aid. There had also been additional training sought such as managing agitation and behaviour in people with dementia, falls and two seniors staff had signed up to train to become assistant nurse practitioners with support from the provider. Dates for training were available on each unit and all staff we spoke with were positive about the training and said the dementia training gave them more confidence in understanding people's behaviours.

Nurses we spoke with said as there were more nurses available, they were able to pass on their knowledge to staff. They thought improvements had been made and the staff team were now more confident and told us, "Things are moving in the right direction; I can see the difference in how the staff support people." At our last inspection one person did not come out of their room due to their challenging behaviour. At this inspection, this person was now receiving one to one support and was seen in the lounge areas. A relative told us, "Staff know [name] as there's more regular staff. It's made a positive difference to [name], they take him to the lounge area now where as they didn't used to."

Nursing staff were up to date with their clinical training and if anyone moved to the home who required different clinical support additional training would be provided prior to admission. The senior staff said they had completed medicines administration training and been observed administering medication, five times

before being signed off as competent to do so, we also observed this recorded in staff files.

Staff told us and we saw they received group supervision which consisted of watching a DVD about dementia followed by a group discussion about dementia care. They said they liked this approach as it involved staff in different roles. Staff did not appear to have regular one to one supervision but felt they could go to the registered manager or another peer for support. We saw that there were plans in place to offer more regular one to one supervision for staff going forward.

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.

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).

Each person had a capacity assessment recorded on the PCS and applications to deprive people of their liberty had been made to the supervisory body where they had identified this was required. For most people, this was about not being allowed to leave the home by themselves. Best interest's meetings had been held when required with the meeting minutes being scanned into the PCS system to enable staff to have instant access to the information. Staff told us they had received training on DoLs and could describe who had a DoLs in place and what restrictions people required to keep them safe.

GP's visited the home twice a week. A book was kept for non-urgent medical issues to be raised with the GP on their next visit. Outcomes of these consultations were noted on the PCS system and all GP and medical appointments were recorded in the daily notes for each person. A report just for the medical entries could be pulled up off PCS, but not all staff were aware of this and the quality manager was planning on arranging a training session with staff to teach them how to complete the task.

The home used a 'React to Red' system for preventing pressure sores. This is a national campaign to raise awareness of pressure ulcer prevention and followed simple steps to avoid pressures sores such as regular repositioning, regular inspections of the skin and reporting any redness immediately. Staff told us that they report any concerns with people's skin integrity to the nurses and they assess the condition and monitor.

The PCS system also held hospital passport information which could be printed off and sent to hospital with someone in an emergency. The passport contained important details about the persons communication, medical history, eating and drinking and any anxieties. This assisted the hospital staff to support the person in strange environments.

The home is purpose built with all bedrooms being en-suite with profiling beds and pressure mattress' suitable for people requiring pressure care management and needing moving and handling. People could choose to have a photo of their choice on the door, for example, favourite football team or old photo and their name to help their room be easily identifiable.

Good

Is the service caring?

Our findings

At our last inspection, staff did not have time to engage with people unless it was task based. We had spoken with a family at the time of the last inspection who had concerns about their relatives care and support while living at the home. At this inspection, we were able to speak to the same family who told us that the home had come on fantastically, staffing levels have improved and maintained and the same levels were consistent at a weekend. One of the relatives told us, "Everyone works so well here now and I feel happier knowing that [name] needs are being met and the staff are so caring towards them. Everyone pops into see [name], they check we are okay, I get involved in [name] care, give breakfast and have been involved in planning for [name] while she is at the home. The home really has come on leaps and bounds everyone works well as a team and they have an excellent leader."

At this inspection, with the increase in staffing levels and training of staff, we found care and support was much more person centred and every staff member from the directors, to care staff to ancillary staff were continually interacting with people as they visited the units. We observed kind, dignified and positive interactions between staff and people living at the home. Staff were patient and encouraging and we overheard people reminiscing to staff and staff respectfully listening.

People told us, "They treat me very well, I love most of them"; "They're very kind, very nice" "I feel very comfortable and safe being here. My kids can come and I don't feel pressured into anything. I just love, I wouldn't go anywhere else." Relatives told us, "They're [staff] very good, 98% are very caring, there are a couple who could be better. 98% of them really do care"; "Most of them are very good and kind"; "When I'm here they treat her with respect"; "It's being able to come and go as I like. You can come in at any time, they don't mind we're here at mealtimes. It's clean and friendly"; "The staff, it's so nice to be known by my name."

People told us that they felt that staff listened to them and acted on what they said. People also said their privacy and dignity was always maintained and staff knocked on doors and ensured curtains were closed when delivering personal care and they were encouraged to wash and dress themselves. One person said, "Sometimes they have to help me get dressed, but they let me do what I can." Another person said "Yes, they will help if needed, they used to call me Miss Independent".

Staff were confidently able to explain how they maintained people's privacy and dignity and said how they would talk with people whist providing care, letting them know what they were doing.

We saw dignity champions were in place for each unit. This was a member of staff who had oversight for promoting staff supporting people with dignity and respect. The staff told us they would speak directly to other staff if they observed practice that did not maintain people's privacy and dignity and felt confident that they could speak to the registered manager or nurses if their concerns continued.

People were called by their preferred name and this information was recorded on the PCS system. One person's care plan stated they preferred to be called 'Grandad' and we observed staff of all designations calling the person this way. The staff had found that this calmed the person down during periods of

agitation.

One person living at the home choose to spend time in their day sat outside the unit office. This was because they preferred the interaction from people walking past them rather than spending time alone in their room. We observed every member of staff, other people living at the home, families and visitors talking to the person or just saying hello. They were also able to listen to music and their facial expressions suggested that they were happy. This was clearly documented in the care plan as the preferred way of spending their day.

Each person had a 'sexuality' care plan. The plan referred to how people preferred to dress or if they preferred to wear perfume. However, we did not see any evidence of peoples preferred sexual orientation or status should they have wished to discuss it or any evidence of where people could be supported to maintain a relationship if appropriate. We recommend that this is reviewed as part of the care planning.

We saw that family had been involved in care planning and conversations with families were recorded on the PCS system. We saw that people had information recorded on their life history of interests and this information was used to talk to people or used as a measure for de-escalating behaviour. We saw that one person who used to be a builder preferred to kneel and providing this was not causing an obstruction, the person anxieties reduced when they did this.

The PCS system and computers were all password protected and offices were kept locked when not in use. This meant peoples information was kept safe.

Good

Is the service responsive?

Our findings

At our last inspection of Four Oaks Care Home in December 2017, we found breaches to Regulations 9 and 16 of the Health and Social Care Act Regulated Activities (Regulations 2014) as care staff did not have the detailed information they needed to provide personalised support for people living at the service. Also, whilst complaints were looked into the responses did not always accurately reflect the situation at Four Oaks at that time.

At this inspection, we found care plans were detailed and staff had access to them at any time using the person centred system (PCS) and complaints were responded to appropriately and factually.

The PCS electronic care planning system had been introduced after our last inspection and every person's care file we viewed on the system were fully completed, up to date and reviewed. Care plans were in place for the delivery and support with personal care, sleeping, mobility, nutrition, communication, continence and medical needs.

Staff told us that they liked the new system and said it was easy to use as they could quickly log on and see what care had been provided and there was additional reminders of what care and support tasks were outstanding.

The front page of each person's file on the PCS system gave a summary of the main care needs and risks presented, for example, if the person was at high risk of falls or had behaviours that challenge. If a person needed two people for moving and handling, if pressure relieving equipment was used or if the person had nutrition needs. This meant that staff had the information needed to support people at the touch of a button.

Care plans detailed equipment needing to be used to keep people safe such as sensor mats, pressure mattresses or moving and handling equipment. When using the iPod, there was a prompt for staff to ensure the equipment had been used and this was recorded as being actioned on the PCS system. Care plans also stated where people required two people for support and not just for moving and handling support. A nurse told us, it was also to reduce people's anxieties and potential challenging behaviour but the service needs to make this clearer in the plan.

The PCS system produced charts for each aspect of care provided for example personal care record, room checked or bed changed. The staff could also add in any additional support provided such as adding in one to one activities. This option was not routinely used and the quality service manager told us they were planning to work with the staff to include when they had spent time talking with people or re-assuring them which is not currently part of the pre-planned care. This meant the system could be amended to capture the whole care and support being provided to everyone.

Additionally, the PCS system allowed staff to register that they had checked on a person every two hours while sleeping and been repositioned. We saw that the checks were happening but no record of

repositioning. We discussed this with staff who confirmed repositioning was occurring and the service manager said the task can be added to the system and the staff will be trained to do this.

People living at the home were supported at the end of their life. People approaching the end of life had a 'death and dying' care plan and two care plans we looked at gave detailed information on the choices they or their families had made at this stage of their lives. We saw information recorded that one person requested that a priest was to administer their last rites and they did not want to be admitted to hospital. A risk feeding assessment was in place to provide small amounts of fluid via a syringe and anticipatory drugs had been prescribed. Anticipatory drugs are used to manage common symptoms at the end of life. The family of this person had been involved throughout this process.

Another person had an advanced care plan discussion recorded with the family which included a Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR). The family had agreed that their relative was not to be admitted to hospital and to be cared for at the home. There were further details of what action the staff should take should the person become unresponsive as the family wished for the person to end their life at the care home.

If a person had a DNACPR in place this was clearly identified on the first page of the PCS care plan. Copies were also held in a file in the office on each unit. This meant the service could respond to people approaching end of life and take into account theirs and their families wishes on how best to be supported.

People told us that activities had generally improved. There was one activities co-ordinator employed and a further co-ordinator had been recruited and was awaiting a start date. People told us, "I enjoy the activities, we play ball games and bingo and some little games. I like the entertainer" "I look after the rabbit and the greenhouse. I like bingo, and painting" "I sleep a lot, and watch television. Bingo, I wasn't a bingo addict until I came in here. Sometimes they have a singer" "I watch some television, I read quite a lot."

A relative told us, "They could take them downstairs if there's entertainment. They don't take them down unless there's a visitor there".

Staff told us that activity provision had been improved there was now a budget for activities to take place, this included having entertainment such as singers at the home or buying games, products for arts and crafts or bingo prizes.

We saw that staff had more time to spend with people to chat or take them to the garden or sun lounge for some quality time. The service had begun to operate a "Question of the day" to initiate conversation with people. This would be using a simple phrase or word like 'ice-cream' to see what memories or conversations it provoked. Staff had received training from an Oomph – a training provider who specialises in engaging activities for older people and we were told that staff engaged a lot more in activities with people.

We saw photos showing people at the home celebrating the royal wedding with a party and ponies had recently visited the home. The activities co-ordinator was in the process of designing questionnaires around meaningful activities for people and was recording the activities people accessed. We will review this on our next inspection. We observed people joining in a pampering activity, having nails painted and the hairdresser visited for part of our inspection.

We observed staff were aware of people's needs and choices. Staff could describe the support each person required and told us that they supported people to make their own choices, for example, what clothes to wear or when to get up. On the first day of inspection, we arrived at 07.15 and very few people were up. Staff

told us this was usual as people preferred to get up later. This meant that people were having their choices promoted and respected.

One person living at the home did not speak English. We saw that staff used an iPad and an app to translate what each other were saying. This worked well as the person was settled at the home and staff were well aware of their needs.

We saw six compliments cards in the reception area. Comments read, 'Thank you to everyone at Four Oaks who has taken such great care of [name]' 'Thank you for making [name] and [name] a part of your family. Although they were only with you for four months, it was lovely that they had their remaining time together' and 'Thank you so much for first class care.'

The service had developed a 'Golden ticket' where people, relatives and staff were encouraged to record their golden moment for the day. Each month, the winning golden moment received a prize. One of the comments from one relative was 'Carer made special effort with [name] meal and ensured he ate his dinner'. This was good for moral and highlighted the good work of the staff team.

We saw complaints were responded to in a timely manner and outcomes were shared with complainants and the wider staff team if required. The complaints we reviewed were answered factually and the service had held the professional duty of candour where something had gone wrong. This meant that the service had apologised and undertaken work to rectify the complaint and improve.

Good

Is the service well-led?

Our findings

At our last inspection of Four Oaks Care Home in December 2017, we found breaches to Regulation 17 of the Health and Social Care Act Regulated Activities (Regulations 2014) as the oversight of the service by the managers and at provider level was not robust and had not identified the issues found in this report. The provider had not acted on feedback from people, relatives, health professionals and staff about the staffing levels. There was an over reliance on a dependency tool to calculate staffing levels.

At this inspection, we found the registered manager had complete oversight of the service and additional support had been given to the home from the area director, the quality service manager and other higher-level management. The deputy manager was also completely supernumerary on the rota and a night manager and clinical lead were also in post. The registered manager was visible on the units and people and relatives were aware of who they were. All relatives we spoke to other than two were very complimentary of the registered manager and agreed that the home had improved hugely. One relative told us, "[Registered manager] is excellent and a good role model for the staff, she has worked hard to get the home to where it is." Another said, "I find the manager very good." A third relative told us, "We haven't seen much of the manager, there was a relative meeting and it was cancelled, I haven't seen much of an improvement, I have concerns over [relatives name]." We asked the relative for their consent to pass this information to the registered manager and advised them to arrange a meeting to discuss their concerns.

Staff told us they enjoyed working at the home and since the last inspection big improvements had been made. Morale was noticeably higher with staff saying they worked well as a team. Nurses were more visible and engaging with staff and we observed staff from all designations working together and supporting each other.

All staff said the registered manager, deputy managers and nurses were approachable. They said they would feel able to raise any concerns they wanted to and felt they would be listen to. Also, staff said the registered manager had been responsive when they had requested changes to their working patterns. We observed the registered manager was visible on the units as they routinely completed a daily walk round and spoke with people and staff.

Staff told us, "I enjoy working here, the staff and the management talk to us and encourage us to do the job well" "We've had quite a few managers, this one has made the most positive changes. Since they have been here, there have lots of changes for the better, they are very supportive" "I like [registered manager] as she is approachable."

Some staff and relatives did highlight to us that there were higher levels of sickness at weekends but the registered manager told us they were aware of the situation and doing what they could to resolve the situation which included employing a team of bank staff and having regular agency staff covering shifts.

The registered manager had developed staff to become champions for areas of the service, this included infection control, safeguarding, dignity, nutrition and activities. Staff attend training and cascade the

information back to their teams.

The staff team had been provided with information about the Care Quality Commissions (CQC) inspection process and about how the inspection would be and what kind of questions inspectors may ask and about the five key questions, safe, effective, caring, responsive and well led. The document was well put together and all staff we spoke with were aware of it and one said that it had put them at ease knowing an inspection was due and they knew a little of how to respond.

Staff told us that regular staff meetings were held. Two meetings were held at 14.00 and 19.00 to enable night staff and all-day staff to attend a handover. Separate nurse meetings were also held. Staff said these were open meetings where they could ask any questions they wanted to. A ten at ten meeting was held each weekday morning where the heads of department met in the manager's office and discuss any concerns or share ideas. At this meeting, staff could share information for example, for anyone who was being cared for in their room and wished for their room to be left by the housekeepers or for the chef if someone's diet had been changed.

Staff meetings were held regularly and used as an opportunity to share information and ideas and as training sessions. We saw there was a good staff attendance at staff meetings and staff told us that they felt their opinion was valued.

We spoke with two professionals from the local authority who told us that they were happy with the way the home had progressed since the last inspection. The local authority will continue to support the service and they felt that the staff were well supported. Both professionals went on to say that they had visited the home in the registered managers absence and the deputy manager had sustained the management of the home in her absence. Additionally, since the last inspection, the service had given 100 percent engagement in adhering to the service plan and had completed a lot of good work around falls and the management of them.

The registered manager and senior management team were in the process of developing a regional training consortium with the local authority to include standardised training for all workers in care homes. They were currently able to access training on the local authority platform and were working with a larger skills organisation to offer diplomas in health and social care to its staff team. This was to enhance the current training offered and for staff to be able to progress in their role. This is in the very early stages so we look forward to seeing this develop in our next inspection,

A computer system called the C360 compliance programme was used to record all accidents and incidents, complaints and prompted when audits required to be completed, for example medicines, care plans, recruitment and infection control. This had been implemented just before our last inspection. Audits had been completed for care plans, medicines (weekly and monthly), infection control, falls and incidents, pressure area care and mattress checks and for the meal time experience. The C360 compliance programme prompted an action plan to be completed for any shortfalls identified during the audit. The audits could be monitored and reviewed by the operations manager and central head office. This meant a quality assurance system was in place. An audit of the meal time experience had been undertaken and had identified improvements needing to be made which we have highlighted in our report.

Random spot checks were completed of the cleanliness of the home and recorded with actions taken to rectify the findings. The registered manager also completed unannounced night visits to ensure the service remained effective at all times.

The service had a business continuity plan in place which incorporated the quality plan and the service objectives as well as information on the home and local services. The business continuity plan gave advise to staff what to do in the event of power failure, flood or severe weather. The quality plan and service objectives was an ongoing document which highlighted what the service wanted to work towards to improve. Going forward, the service plans to develop the latest ideas in end of life and dementia care. We will review the progress at the next inspection.

People and relative's questionnaires were sent out annually however none had been sent out since prior to our last inspection. We were told that an iPad was on order to leave by the signing in book for people to submit their feedback. We will review this on our next inspection.

From 1 April 2015 it has been a legal requirement of all services that have been inspected by the CQC and awarded a rating to display the rating at the premises and on the service's website, if they have one. Ratings must be displayed legibly and conspicuously to enable the public and people who use the service to see them. During this inspection we saw that the rating from our last inspection was clearly displayed in the reception area and was also on the service website.