Unityone Ltd

Oakwood Rest Home

Inspection report

78-82 Kingsbury Road
Erdington
Birmingham
West Midlands
B24 8QJ

Tel: 01213738476
Website: www.oakwoodresthome.co.uk

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 12 and 14 April 2016. This was an unannounced inspection.

On our last inspection in October 2014, we found that the service required improvement in three out of the five areas we inspected against, namely is the service effective? Is the service responsive? And is the service well-led? This was because we found that people's rights to make decisions and choices were not always protected because their abilities to make such decisions had not been assessed or lawfully protected. We also found that registered manager had not kept us up to date with the relevant legislation relating to providing care with lawful consent. Furthermore, we found that the staff we spoke with had little understanding about dementia care and care plans were not always kept up to date to reflect peoples changing needs.

Oakwood Rest Home provides accommodation and personal care for up to 30 older adults. At the time of our inspection there were 23 people living at the home.

There was a registered manager in post. 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.

At the time of our inspection we found that the registered manager was not always fulfilling their responsibilities for meeting these requirements because information that they were legally required to share with us and other agencies such as the Health Protection Agency, was not sent. We also found that the service did not consistently implement effective quality monitoring processes to ensure that the risks to people's health, safety and well-being were identified, monitored or addressed. This included risks relating to effective infection prevention and control. Therefore, we found breaches of the regulations.

People were supported by staff to take their medication but this was not always in the way in which it was prescribed. Protocols were not in place to support staff to know when a person may require their medication, if they were unable to ask for it themselves.

We found that people were not always supported to access the community and whilst staff did attempt to engage people in activity, this was not always person-centred and did not always reflect their hobbies and interests.

People were supported by enough staff who were kind and caring, and who had an adequate knowledge base and skill set to ensure people were cared for and their needs were met. People and/ or their representatives were involved in the planning and review of their care and care was provided with consent. We found that people were treated with respect and their privacy and dignity was protected.

Everyone we spoke with knew how to complain and they were confident that any concerns raised would be addressed by the management team. The provider also sought feedback from people who used, visited or worked at the service and used this information to make improvements where necessary.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

People were not always protected from the risks of cross infections because the service was not adhering to policies, procedures and guidelines.

People did not always receive their prescribed medicines as required

People were supported by enough members of staff to meet people's needs.

People were protected from the risk of abuse because staff were aware of the processes they needed to follow.

Is the service effective?

Good

The service was effective

People received care from staff who had received adequate training and had the knowledge and skills they required to do their job effectively.

People received care and support with their consent and people's rights were protected because key processes had been fully followed to ensure people were not unlawfully restricted.

People's nutritional needs were assessed and monitored to identify any risks associated with nutrition and hydration and had food they enjoyed.

People were supported to maintain good health because staff worked closely with other health and social care professionals when necessary.

Is the service caring?

Requires Improvement

The service was not always caring.

People's needs were not always met because the provider had not ensured that communication aids were readily available for

staff to use to help them to communicate with people who had more complex care needs.

People were supported by staff that were kind and caring and who knew them well, including their personal preferences, likes and dislikes.

People were cared for by staff who protected their privacy and dignity and who respected their equality and diversity needs.

People were encouraged to be as independent as possible.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People had the opportunity to engage in group and individual social activities however, this was not always tailored to their individual needs, hobbies or interests.

People were supported to maintain relationships with their friends and relatives.

People and their relatives felt involved in the planning and review of their care.

People were encouraged to offer feedback on the quality of the service and knew how to complain.

Is the service well-led?

Requires Improvement

The service was not always well led.

The management team had some systems in place to assess and monitor the quality and safety of the service; however these were not always effective in identifying shortfalls within the service.

The management team had not ensured that information that they are legally obliged to share with us and other agencies, was sent.

Staff felt supported in their work and reported Oakwood rest home to have an open and honest leadership culture.

Oakwood Rest 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 took place on 12 and 14 April 2016. The inspection was conducted by one inspector and an Expert by Experience. An Expert by Experience is a person who has experience of using or caring for someone who uses this type of service.

As part of the inspection we looked at the information that we hold about the service. This included notifications from the provider about deaths, accidents/incidents and safeguarding alerts which they are required to send us by law. We also received feedback from the local authority with their views about the service provided to people at Oakwood Rest Home.

During our inspection, we spoke with 13 people who lived at the home, five relatives and 10 members of staff including the provider, the registered manager, two team leaders, four care assistants, a member of the catering staff, a house keeper and a laundry assistant. We also spoke with three visiting professional's to understand their experience of the service.

Some of the people living at the home had complex care needs and were unable to tell us about the service they received. Therefore we used a tool called the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

We reviewed the care records of three people, to see how their care was planned and looked at the medicine administration records as well as observed a medication administration round. We also looked at communication records including staff hand-overs, safeguarding records, training records for staff and at three staff files to look at recruitment and supervision processes. We also looked at records which supported the provider to monitor the quality and management of the service, including audits relating to health and safety, infection control, accidents and incident records and compliments and complaints.

Requires Improvement

Is the service safe?

Our findings

During our inspection we received information to suggest that a person who had received care at Oakwood Rest Home may have transferred an infectious illness to another service. The registered manager told us that four people and two members of staff had recently experienced symptoms of diarrhoea and/or vomiting. Therefore we decided to inspect the service against an additional key line of enquiry relating to infection control.

Staff we spoke with were aware of some of their roles and responsibilities relating to infection control including, strict hand washing procedures, enhanced cleaning and laundry processes and the need to encourage 'bed rest' to isolate and minimise the risk of cross infection. One member of staff said, "If a person is sick or they have diarrhoea, we encourage them to stay on bed rest for infection control purposes". Another member of staff told us, "Any soiled clothing or bed linen is put in a red bag [used for classifying contaminated linen or clothing] and tied up; this can then all go in to the washing machine, including the red bag, to prevent cross contamination; we wear gloves and aprons". A member of the laundry staff showed us the laundry facilities and demonstrated the appropriate process they would follow for soiled items during an outbreak of an infectious illness. This included handling items with protective clothing, following strict hand washing procedures, keeping contaminated items separate and washing contaminated items at a higher temperature.

However, we found that the registered manager did not have effective systems in place to manage and monitor the prevention and control of infection. Records we looked at including people's daily report notes and staff hand-overs showed that 16 people and two members of staff had experienced symptoms of diarrhoea and/or vomiting from 2 April to 12 April 2016. The registered manager told us that they were unaware of the exact number of people affected and had not identified this as a potential outbreak. This meant that the registered manager had failed to monitor and report infections in keeping with the Health and Social Care Act 2008 Code of Practice on the prevention and control of infections and related guidance.

We found that the provider had failed to ensure that key policies and procedures around infection prevention and control were in place and kept up to date, implemented and adhered to appropriately. The service had an outdated version of the recommended guidance dating back to 2006 and despite some of the information being similar to the guidance in the more recent version; the service was not adhering to either. There were no clear protocols in place to guide staff on effective infection prevention and control deriving from this guidance and there were no contact details of external agencies that were likely to be involved in offering advice and information on outbreak management, including the lead nurse for infection prevention and control within Birmingham Community Health Care Trust. The registered manager stated that they felt it was the responsibility of the GP to declare and report an outbreak.

The registered manager also informed us that the service had an Infection Control Lead; however the member of staff identified was unaware of this role. The staff member told us, "I was the infection control lead before I left in 2014; but I was not told that this role had been reinstated when I returned to work for the service six months later". There was no evidence of any additional training or support for the person

identified for this role and they (and the registered manager) were unaware of any external support agencies who could offer advice and guidance in this area. This meant that the service was not accessing the support available to enable them to promote people's safety.

Staff we spoke with and records we looked at showed that people had been encouraged to remain in their bedrooms on 'bed rest' in an attempt to isolate the spread of infection. However, we found that records were not clear or robust enough to ensure that other people living at the home were protected from the risk of cross infection. This was because the records did not detail the specific times or number of episodes that a person had experienced the symptoms and therefore it was not clear whether a person had been clear of symptoms for a total of 24 hours before returning to communal areas as per guidance to prevent cross infection. Furthermore, they had also failed to notify the Health Protection Agency by contacting their local Health Protection Unit (HPU) of a potential outbreak within the home. Guidance provided to care homes by the Department of Health states that the registered manager should notify the local Health Protection Unit if two or more people present with the same symptoms of an infection, including diarrhoea and/or vomiting.

In addition, the registered manager told us they had closed the home to visitors from 6 to 8 April 2016. We saw that people continued to receive visitors during this period. Records showed that people considering whether to move to Oakwood had also visited during this period meaning they were put at risk of contracting the infection and taking it back into another service. Another person had also experienced symptoms of diarrhoea in the early hours of the morning and was still transferred to another care provider in the afternoon. The registered manager of Oakwood rest home told us that they had escorted this person to their new care home alongside another member of staff, and that neither of them had been told that the person had been symptomatic earlier in the day. Therefore, they did not disclose this person's infection status to the new provider in order to prevent cross infection and they recognised that this was due to failed communication processes both internally within the home and externally from one organisation to another. Subsequently, we were told that an outbreak had occurred at the other location.

With regards to the cleanliness of the environment, we saw that most areas of the home appeared clean and tidy and that hand-washing facilities and antimicrobial hand rub 'alcohol-gel dispensers were readily available. However, we saw that one of the shower rooms looked unclean and in a poor condition with a strong odour which reflected poor preventative maintenance. The registered manager acknowledged these observations and independently passed comment on the odour coming from the room; they agreed that the shower room was in need of attention and handed this over to the provider at the time of our inspection visit. We also saw that the conservatory appeared unclean with pet hair and other debris present on the furniture and carpet, again with a strong odour evident within the room. The registered manager explained that the two house-keepers had called in sick (one as a result of diarrhoea and vomiting) during the first day of our inspection and that the care staff can only pick up essential cleaning duties. However, despite the recent and potentially on-going outbreak; alternative cleaning arrangements had not been arranged to cover this absence.

Subsequently, we found the provider to be in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because they had failed to effectively assess the risk of, and prevent, detect and control the spread of infections. You can see what action we have asked the provider to take at the end of the report.

People we spoke to told us they received their medication when they required it and we were told that all of the people living at the home required support to take their medication. One person we spoke with told us, "They give me my medication when I need it". During our inspection we saw that medications were stored appropriately and staff that were responsible for medication were aware of the disposal policy for unwanted

or refused medication. Processes were in place to identify missed medication early and there was a good rapport between the provider, GP and local pharmacy to ensure people received their medication on the day it was prescribed.

We were told that only team leaders administered medicines in the home and during our inspection we observed a medication round. We saw a team leader administering medicines to people safely and effectively. We saw how medication that was prescribed on an 'as and when required basis (PRN)' for pain relief was offered to people before being administered. However, we did not see any PRN protocols in place for staff to refer to, that detailed signs or symptoms to suggest medication would be required if the person was unable to tell staff they needed or wanted it. For example, the medication administration records (MAR's) for one person who had been prescribed medication on an 'as and when basis' for 'agitation' had been given the medicines routinely at 5pm each day. The team leader informed us that the person, "Was better on it" and we saw that they continued to administer the PRN medication on a regular basis rather than when required. We fed this back to the registered manager at the time of our inspection and explained that the service would benefit from a PRN protocol for staff to know what signs to look for to suggest a person required the medication (if they cannot tell staff themselves) and what other techniques they could try first. The registered manager acknowledged that this would be beneficial and explained that the person we were referring to also required a medication review.

People we spoke with told us they felt safe living at the home and that there were enough staff available to meet their needs. One person told us, "The staff are good; I am safe here". Another person said, "I am contented". A different person told us, "I see enough staff around me" and a relative we spoke with said, "I chose this home because there always seemed to be enough staff around [to help people] and there is". Another relative told us, "My aunt was here first and I knew she was safe and well-looked after, so when Mom needed care, I thought of here straight away; now I can visit them both together".

We saw a high visibility of staff available in the communal areas during our inspection, which appeared to offer reassurance to many of the people living at the home and all of the bedrooms had integral sensor mats so that staff would be made aware if anyone needed support in their bedrooms. We saw that staff were responsive to people's needs and they assisted people when they required it; we did not see anyone having to wait for long periods of time in order to get their needs met.

Staff we spoke with felt that there were enough staff available to ensure people were kept safe and well cared for. One member of staff told us, "It's very busy but there are enough of us". Another member of staff said, "I think there is enough staff; we allocate jobs to do in the mornings and we all work together as a team to ensure everything gets done and people are looked after".

Staff we spoke with knew what action to take to keep people safe from the risk of abuse and avoidable harm. One staff member told us, "We all have safeguarding training, if I had any concerns about a person's safety I would report it to the office immediately and tell the manager or a team leader, they would escalate the concerns then". Another staff member told us, "We know people so well that I would notice any changes and notice if anything wasn't right like if they were sad or if I saw bruises. I would report it straight away, but I have never had any concerns here". We saw that staff had received safeguarding training and they were knowledgeable in recognising signs of potential abuse; staff knew how to escalate concerns about people's safety to the provider and other external agencies. Information we hold about the provider showed us that they were also aware of their roles and responsibilities with regards to reporting safeguarding concerns to the local safeguarding team in order to keep people safe.

Staff we spoke with and records we looked at showed that people had some risk assessments in their care

files. These included moving and handling, falls, pressure care, medication and nutritional risks. The risk assessments generally detailed what actions staff were to take to reduce any risks, for example, what equipment was to be used to help move people safely. For example, one person's risk assessment identified a high risk of falls and it advised staff that should this person experience a fall then they needed to use a hoist to help the person up off the floor. One member of staff we spoke with confirmed that they adhered to the risk assessments when caring for people and said, "No-one living here needs to be hoisted unless they fall; for example [person's name] is at risk of falls and if he falls we have to use the hoist and a large sling". Risk assessments were evaluated monthly and changes were made as necessary.

We saw the provider had a recruitment policy in place and staff had been appropriately recruited via a formal interview, references, and a Disclosure and Barring check. The Disclosure and Barring Service (DBS) helps employers make safer recruitment decisions and prevent unsuitable people from working with people who require care. Staff we spoke with told us they had completed a range of pre-employment checks before working unsupervised.

Good

Is the service effective?

Our findings

Everyone we spoke with and records showed that the staff had the knowledge and the skills they required to do their job safely and effectively. One person told us, "Staff are good". A relative told us, "The staff are very good here". One member of staff said, "We have lots of training; some is mandatory [training that the provider expects all staff to do] and extra training if we want to". Another staff member told us, "We have all the training we need including safeguarding training, manual handling, health and safety". A new member of staff told us that they received, "A good induction programme" when they first joined the organisation which included an introduction to the home, training and opportunities to shadow other experienced members of staff to gain practical experience 'on the job'.

We were told and records showed us that the provider offered regular team meetings and supervision to staff and they felt supported in their jobs. One member of staff told us, "We are very well supported here; the [registered] manager is very supportive and approachable". They said, "We have team meetings regularly which are useful; we talk about changes [to the service] and we see results". Another member of staff told us, "We are looked after here too; it [management] is supportive; she [registered manager] always makes sure we are all ok". A different member of staff said, "We have supervision; we can talk to [registered managers name] about anything and she will listen and help us".

People we spoke with told us that staff involved them in making choices and decisions about their care. We found that care was provided to people with their consent. One person told us, "They ask us what we want". We saw that staff offered people choices throughout the day and care plans we looked at promoted choice and independence.

It was evident when speaking to the registered manager and the staff that they had an understanding of the Mental Capacity Act 2005 (MCA). The MCA 2005 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 we spoke with were able to give examples of how they worked within these legal parameters and protected people's rights. Staff we spoke with confirmed they had received training on the Mental Capacity Act (2005). One member of staff told us, "We ask people what they want or need and give them choices; most of the people living here can make choices on day to day decisions, they just communicate differently with us for example with gestures or facial expressions and we get to know what people like". Another member of staff said, "We talk to people and give them choices in different ways, like we show them different clothes and they pick what they want to wear for example". During our inspection we saw the cook went around the home to ask people individually what they would like to eat at lunch time; however we did not see any evidence of enhanced communication styles to support people who had difficulty with verbal communication to make choices, for example, with the use of pictures. We fed this back to the registered manager and suggested that the service would benefit from visual aids to promote choice, independence and consent.

Deprivation of Liberty Safeguards (DoLS) requires providers to identify people in their care who may lack the mental capacity to consent to care and treatment. They are also required to submit an application to a 'supervisory body' for the authority to deprive a person of their liberty within their best interests in order to keep them safe, for example. The provider was able to articulate their understanding of DoLS and was aware of their responsibilities. We saw that where DoLS applications had been submitted, copies of the forms were in place and where people had a DoLS authorisation, there was a care plan detailing why. One care plan stated that staff were to continue to encourage the person to make everyday decisions. If any complex decisions were to be made a mental capacity assessment was to be undertaken and all relevant parties were to be involved in any decisions. This ensured any decisions made on behalf of people were made in their best interest and was done so lawfully. One member of staff said, "If a person lacks the capacity to make decisions for themselves we can consult their care plan which will tell us how they like to be cared for, this has usually involved a best interest meeting where family have been involved to ensure decisions have been made within their best interests".

Everyone we spoke with told us they had enough to eat and received food they enjoyed. One person told us, "The food is good". Another person said, "The foods ok, you know; we get enough". People were offered snacks and drinks throughout the day and we saw drinks were available for people to help themselves as required. We saw people were offered two choices at meal times and were given alternatives to what was on the menu if they required it.

We observed a meal time during our inspection and we saw that people's individual needs were catered for at meal times. We saw that lunch time was a social event and people appeared to enjoy their meals in a calm and pleasant atmosphere. People's independence was promoted during the meal time but staff were available to assist people where needed. We also saw that staff were patient with people and did not rush them to finish their meals. Staff encouraged people to eat as much as possible to help them remain healthy.

People we spoke with and records showed that nutritional risk assessments and care plans were in place for people. These detailed people's specific needs and risks in relation to their diet. One person told us, "I have had to change my diet because I am diabetic now". Records showed people's weights were closely monitored to help ensure their nutritional needs were being met and where people were identified to be at high risk associated with their diet or fluids, they were referred to the appropriate medical professionals. For example, one person's weight chart showed that they had been losing weight and that the GP had been notified. We saw that this person had been prescribed fortified supplement drinks for the management of risks associated with malnutrition.

People we spoke with told us they had access to doctors and other health and social care professionals. One person said, "I go to medical appointments if I need to, like I have been to the dentist once since I have been here, but the GP comes here if we need to see him". A relative we spoke with told us, "They [staff] contact my sister if dad has any appointments with a social worker or anyone else in case we want to attend". We saw a GP visiting on the day of our inspection and medication that was prescribed was delivered by the pharmacist later that day. Records we looked at confirmed that people were supported to maintain good health and any health care concerns were followed up in a timely manner. We also saw a hairdresser and an exercise to music personnel visiting the service during our inspection; both of whom reported to visit the home regularly to support people's health and well-being.

Requires Improvement

Is the service caring?

Our findings

During our inspection, we saw that staff appeared caring in their approach to people and interacted with people with warmth and compassion. Staff we spoke with told us that they adapted their communication and interaction skills in accordance to the needs of individual people. One member of staff told us, "Some people can't tell you what they want verbally but we get to know them well enough to know what they need. For example [person's name] has limited verbal communication but I know if she stands up and messes with her skirt or looks restless that she probably needs the toilet, so I give her that option. I can also tell by changes to their [people's] body language and facial expressions".

However, we found that the provider had not always ensured that communication aids were readily available for staff to use to help them to communicate with people who had more complex care needs such as dementia. We saw that one person had been assessed by a specialist service and had been recommended a visual communication board to aid communication. However, this person's care plan did not reflect this and the service had not implemented these recommendations which meant that the person was not supported to communicate effectively. We fed this back to the registered manager and to the provider at the time of our inspection. We observed that the service would benefit from a more dementia friendly environment which included adapted communication and visual aids to support people with dementia to feel more secure within their home. Both the provider and registered manager acknowledged and agreed that this was an area in need of improvement.

Everyone we spoke with were complimentary about the staff team. One person told us, "The staff are nice." Another person told us, "They [the staff] are lovely". Relatives we spoke with told us they were happy with the care their loved ones received at the service. One relative said, "The staff look after them [people] in every way; they [staff] are lovely" Another relative told us, "I know my relatives are well looked after; the girls [staff] are lovely". A different relative said, "The staff are kindly".

We found that people received their care and support from staff that knew and understood their history, likes, preferences and needs. One person said, "They [staff] get to know us well". Another person told us that they go to bed when they are ready in accordance with their preference. Staff we spoke to confirmed that they considered people's preferences when providing care. One member of staff said, "For example, we know who likes to get up early and who prefers to lie in, so we make sure we plan around them when we offer personal care in the mornings". Records we looked at confirmed that people and their relatives (where required) had been involved in the planning of their care and were encouraged to make decisions about the support they received. One relative told us, "My sibling was involved in the planning when [person] first arrived to make sure they [staff] knew everything they needed to know [about the person], and they attend reviews and meetings".

Discussions we had with the staff demonstrated to us, they had a good understanding of people's needs and they were able to build positive relationships with people. One member of staff told us, "We know the residents very well." Another member of staff told us, "We know what people like; for example [person's name] loves knitting, [another person's name] likes trains, he has lots of books and models of trains". We

observed positive interactions between staff and people who used the service and saw people were relaxed with staff and confident to approach them for support. We saw that when people called out for staff they responded quickly. It was clear that there were friendly relationships between the staff and the people using the service. There was a very calm and relaxed atmosphere in the home during the inspection.

People we spoke to told us that the staff promoted their independence. One person said, "I like to do things myself". Another person said, "Sometimes I need a bit of help but I like to do as much as I can for myself". Staff we spoke with told us how they encouraged people to remain as independent as possible. One member of staff told us, "We try to encourage people to do as much as they can for themselves so they can stay independent; for example [person's name] likes to wash herself, so we give her everything she needs and just help her with the bits she can't reach". Another member of staff said, "If people can do things themselves we let them". During our inspection we observed people moving around the home freely and appeared to have some level of independence.

People we spoke with said that the staff treated them with dignity and respect. One person said, "We have our privacy, you know, we have our own rooms and toilets in our rooms". When we asked another person about how staff respected them they told us, "They are kind to me and I am happy". Staff we spoke with were mindful of people's rights to have their privacy and dignity respected. One member of staff told us, "We pull curtains closed and shut doors [during personal care] and always knock before we enter a room". Another member of staff told us, "We keep peoples business private; we don't discuss anything with other people or in open spaces and we are discrete when it comes to personal issues like asking people if they need to use the toilet". We saw that staff addressed people by their preferred names and respected people as individuals. We also saw that rooms were personalised with people's personal possessions and keepsakes and the staff reported that people can bring their own furniture and decorate their own rooms if they want to.

We found that equality and diversity was promoted within the home. People we spoke with and observations we made showed us that different cultural needs were catered for at meal times. One relative said, "There is the option [of Caribbean food] but he [person] actually likes the English food; his appetite and taste buds have changed". Staff we spoke with told us they respected people's individuality. One member of staff said, "We respect peoples' choices and preferences". Another member of staff told us, "We have the church visit for people who are religious". We found that Christianity was the only faith that was currently being practiced by some of the people living at the home, which justified why other religious organisations did not visit. However, the registered manager told us that if a person of a different faith wanted to practice their religion they would welcome it within the home.

Requires Improvement

Is the service responsive?

Our findings

Some of the people we spoke with told us that they enjoyed the activities at Oakwood including bingo, singing and board games. One person said, "They do bingo and an exercise man comes in to do exercise to music; but it's not my cup of tea, I don't get involved". We saw staff promoting engagement in different activities; however these were not considered to be person-centred, specific to people's hobbies and interests. Instead, we observed some people sitting passively or sleeping in their chairs, unengaged or just un-interested in the activities being offered. For example, we saw one person was sat in their chair with a colouring book and pens on a table in front of them. We asked them about their interest in colouring and they said, "Oh it's not mine, I don't do that, it's just been put there, but I'll leave it there in case someone comes back for it".

We also found that despite many people having the ability to passionately express their interests and hobbies, these were not being maximised or extended within the home. For example, one person told us, "I used to be an engineer, if you showed me the parts I'd tell you where they all belonged". Another person told us, "I used to be a yoga instructor" and they proceeding to instruct us and their visitors on some yoga moves. This prompted their visitor to comment on another one of their favourite past times card making, and they agreed to bring some materials in for them to use so they could re-engage in this hobby again as this had not been facilitated by the home.

We were told that the home did not employ an activities co-ordinator and that all of the staff had a shared responsibility for promoting activity. However, we found that people did not have care plans relating to their hobbies or interests and therefore staff did not always know how to tailor activities specific to people's individual needs and interests. For example, we saw one person to be actively walking around the lounge area looking for something to do, talking to the TV screen and saying that they needed to go to the shops. During the day, no attempt was made to enable this person to engage in a purposeful task but instead, staff repeatedly assisted them back to their seat. We also looked at a person's care record and found that a specialist service had assessed and reported the persons interests in maintaining their independence with daily activities such as preparing a sandwich and doing household chores. However, this was not reflected in the person's care plans and there was little evidence throughout the inspection that people were encouraged to engage in purposeful activities such as domestic tasks within the home. The registered manager told us that some people do like to dust the ornaments and lay the tables but acknowledged that more could be done to develop the use meaningful activity within the service.
Everyone we spoke with told us that people do not go out of Oakwood on day trips or to engage in any other community activities, unless they go out with their relatives or friends. One person told us, "I can't go out on my own because I use a wheelchair, so it's difficult; I just don't go out". Another person said, "I would like to go out, but I need transport". A member of staff we spoke with said, "We don't do day trips or anything because we haven't got a mini-bus and staffing levels wouldn't really permit it; but it is a shame for people who don't have family; they don't get to go out". We fed all of this back to the registered manager and the provider at the time of our inspection and explained that people should be given the opportunity to live enriched and meaningful lives. Both of them acknowledged and agreed that this was an area in need of improvement.

We found that people were supported to maintain personal relationships and social contact with their relatives and friends from within the home. We saw many people enjoying visits from their family and friends throughout our inspection and relatives we spoke with told us that they were always made welcome. One relative told us, "I come every other day; it's never a problem me being here".

We found that people and/or their representatives were consulted about their care plans and how they would like to be cared for. A relative we spoke with confirmed that they were involved in the initial assessment and contributed to the care plans. They said, "Yes, they often speak with me about mom and what she needs or any changes". During our inspection we saw the registered manager meeting with a person who was being admitted to the home and their relative, to discuss what they wanted included in their care plans. This ensured people's individual needs and preferences with regards to their care were taken in to account.

People we spoke with and records showed that people had formal care reviews periodically and that people, their relatives and social workers were involved in the reviews. This ensured that people were satisfied with the service they were receiving and their needs were being met. A member of staff we spoke with told us that their mother used to be a resident at the home and that she was involved in all of the assessments and reviews regarding her mother's care; both before and during her employment with the service.

Some of the people we spoke with and records showed that the provider often asked for feedback on the quality of the service from people living at the home, relatives and professional visitors. One person said, "They ask us what we think sometimes". We saw that many of the people living at the home were able to express their thoughts and opinions freely but we did not see any evidence of residents meetings. However, staff we spoke to and records showed that relatives were invited to meetings to provide feedback and contribute to service development. A relative told us, "We are invited to meetings but we can't always make it". We saw that invites were sent out to relatives but the response rate was poor. We also saw that questionnaires had recently been sent out to relatives and the service was awaiting their return. We also saw that people were encouraged to raise any concerns with the registered manager at any time and people we spoke with knew who the registered manager was.

People we spoke with told us they knew how to complain. One person said, "I would talk to staff if I wasn't happy". A relative we spoke to told us, "I would speak to the [registered] manager's name if I needed to complain". During our inspection, the registered manager told us that there were no outstanding complaints but explained to us an effective complaints procedure should one arise.

Requires Improvement

Is the service well-led?

Our findings

During our inspection, we saw that there were some systems in place to monitor the quality and safety of the service including feedback forms and surveys, staff recruitment processes and some quality monitoring audits, such as medication administration audits, weight management audits and care plan reviews. However, the implementation of such quality monitoring procedures had not been implemented consistently across the service and the provider had failed to identify and manage some of the shortfalls we found during the inspection. These included concerns raised about the cleanliness and maintenance of some of the bathing facilities, issues around infection control, and the lack of meaningful and purposeful engagement and access to community services. We also found that where quality monitoring had occurred, there was little evidence of data analysis to demonstrate how the provider has interpreted the information and what action had been taken or lessons learned. Therefore, whilst we found the registered manager to be responsive to some of our feedback during our inspection, improvements need to be made so that the provider can reliably identify, monitor and demonstrate how they have used the information to address any issues independently in the future.

We found the provider to be in breach of Regulation 17 of the Health and Social Care Act 2008 (regulated Activities) Regulations 2014 because systems and processes had not been established and/or operated effectively to assess, monitor and improve the quality and safety of the service, nor to mitigate the risks relating to the health, safety and welfare of people using the service. You can see what action we have asked the provider to take at the end of the report.

The service was required to have a registered manager in place as part of the conditions of registration. There was a registered manager in post at the time of our inspection. However, information we hold about the service and records we looked at during our inspection showed that the registered manager was not always meeting the registration requirements of CQC. They had not ensured that information that they were legally obliged to tell us about, including safeguarding concerns, incidents that had been reported to or investigated by the police or authorisations relating to the deprivation of liberty safeguards, were sent. This was found to be a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009. You can see what action we have asked the provider to take at the end of the report.

We asked the registered manager to tell us about their understanding of the Duty of Candour. Duty of Candour is a requirement of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 that requires registered persons to act in an open and transparent way with people in relation to the care and treatment they received. The registered manager was able to tell us their understanding of this regulation and how they reflected this within their practice. We found the registered manager to be open in their communication with us throughout the inspection, and information we asked for was provided to us if it was available. The registered manager also explained how the complaints procedure ensured that where issues had been raised, the service conducted a thorough investigation and a report was written to identify any areas of service deficiency with acknowledgment of accountability and recommendations to improve practice. We saw evidence of this during our inspection.

Staff we spoke with told us they felt supported in their work and that the service promotes an open and honest culture. One member of staff told us, "Communication is good here, [registered manager's name] is approachable and we can go to her with anything; they are open with us about stuff [relating to the service] and tell us what we need to know".

Staff we spoke with were also aware of the service having a whistle-blowing policy. Whistle-blowing is the term used when someone who works in or for an organisation raises a concern about risks to people's safety, malpractice or illegality without the fear of workplace reprisal. They may consider raising a whistle-blowing concern if they do not feel confident that the management of their organisation will deal with their concern properly, or when they have already raised a concern but the problem within the organisation or with the provider has not been resolved. One member of staff told us, "If I had any concerns I would report it straight to the manager and if nothing was being done or if the concerns were about the manager, I could raise it with social services or yourselves [CQC]; we have a whistle-blowing policy". Information we hold about the provider showed that there had not been any whistle-blowing concerns raised since our last inspection.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents The registered manager had not ensured that information that they were legally obliged to tell us about was sent.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to effectively assess the risk of, prevent, detect and control the spread of infections.

The enforcement action we took:

We served a Section 29 Warning Notice and have asked the provider to submit an action plan of how they intend to meet the requiremenfs of the regualtion and to be able to demonstrate their compliance with the regulations by 1 July 2016

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems and processes had not been established and/or operated effectively to assess, monitor and improve the quality and safety of the service to mitigate the risks relating to the health, safety and welfare of people using the service

The enforcement action we took:

We served a section 29 Warning notice and have asked the provider to submit an action plan of how they intend to meet the requiremenfs of the regualtion and to be able to demonstrate their compliance with the regulations by 1 July 2016