Prime Life Limited

Charnwood Oaks Nursing Home

Inspection report

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Ratings

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

Overall summary

The inspection took place on 22 July 2015 and was unannounced. We returned announced on 24 to complete the inspection.

At our last inspection in July 2014 we identified a breach to Regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which following the legislative changes of 1st April 2015 corresponds to Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The breach occurred because some staff were not supported through training and supervision to effectively support people who at times presented behaviour that challenged others. At this inspection we found that the provider had made improvements to the quality of training and support. People who presented behaviour that challenged others were better supported although we

Summary of findings

saw an isolated example were a non-permanent care worker had not effectively supported a person. We were told that non-permanent staff had not received training at the time of the inspection, but training was scheduled.

Charnwood Oaks is a nursing home that provides accommodation for up to 84 people who require nursing or personal care. At the time of our inspection 84 people were using the service. Charnwood Oaks consists of four care units each with accommodation and communal areas. All bedrooms were en-suite.

The service had a registered manager. 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.'

The service had a history of safeguarding investigations most of which were connected to incidents between people using the service. The provider had taken action to reduce the risk of such incidents occurring, but a serious incident had taken place in May 2014 which might have been avoided if staff had been effectively deployed. We found lapses to attention, for example not ensuring that storage rooms were kept locked. We found a similar lapse at a previous inspection after which we were told that new coded locks would be fitted to storage rooms, but they hadn't been fitted. We saw a door to a stairwell being held ajar by equipment in an area where people using the service were not supervised. This posed risks of injury through falls to those people. Staff acted after we had brought these matters to their attention.

Staff knew how to identify and report concerns about people's safety. There were enough staff to meet the needs of people using the service, although staff were not always effectively deployed leaving people unsupervised, for example when they walked along corridors where people's bedroom doors were open and storage rooms were unlocked.

People received their medicines at the right times. The provider had safe arrangements for the management of medicines.

People were mainly supported by staff with the right skills and experience. People told us that some staff were better than others. We observed that to be the case and found that `bank staff' who worked at the service less regularly than other staff had not received the same level of training.

Staff understood the relevance of and acted in accordance with the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards when they supported people.

People were supported with their nutrition. The service had not always responded promptly when people had experienced unplanned weight loss, for example by involving dieticians in people's care. A safeguarding investigation by the local authority found that a person's health had not been adequately monitored and that this was a contributing factor to a serious incident that occurred.

The majority of permanent staff we saw demonstrated care and compassion in the way they supported people. We saw lapses by a very small number of staff which we brought to the provider's attention and they told us action would be taken to address this through training and closer supervision.

People using the service and their relatives were involved in making decisions about their care and support. People and relatives we spoke with told us they received information they needed about the service before and after they began to use it.

Staff respected people's privacy and dignity. They were discrete when they provided care and support. The provider took action to reduce the instances of people's privacy being disturbed by other people walking into their rooms.

People's care plans were focused on their individual needs. People were supported to maintain their independence by being supported to follow their hobbies and interests. People using the service and their relatives knew how to raise concerns and their views were acted upon.

People using the service, their relatives and staff were involved in developing the service. The provider acted upon their feedback. The registered manger and senior

Summary of findings

staff monitored staff care practice. The provider had effective procedures for monitoring the quality of the service and took action to make improvements in areas identified by them as requiring improvement.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires improvement

The service was not consistently safe.

Staff understood how to recognise and report concerns about people's safety.

Staff were not always effectively deployed which meant people were not supervised in areas where they were exposed to risk. Wheelchairs that were unclean or damaged that were taken from storage area and used.

People received their medicines at the right time.

Is the service effective?

Requires improvement

The service was not consistently effective.

People and their relatives told us that they were mainly satisfied with the quality of staff but told us some staff were better than others. Bank staff had not had the same level of training or support as permanent staff.

Staff had not always responded promptly to changes in people's health.

Is the service caring?

Good

The service was caring, although a very small number of staff were not as skilled as most with supporting people with care and compassion. This issue was being addressed by the provider.

People using the service and their relatives felt involved in decisions about their care and support.

Is the service responsive?

Good

The service was responsive.

People received care that was centred on their individual needs.

People had access to a range of activities including activities that supported them to maintain their interests and hobbies.

People and relatives knew how to raise concerns about the service. We saw that the provider had acted upon concerns by reviewing and improving procedures.

Is the service well-led?

Good

The service was well-led.

People using the service, their relatives and staff were involved in developing the service.

The service was organised into four units each with team leaders who reported to the registered manager.

Summary of findings

The provider had effective arrangements for monitoring the quality of the service.	

Charnwood Oaks Nursing Home

Detailed findings

Background to this inspection

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

This inspection took place on 22 July 2015 and was unannounced. We returned announced to complete the inspection on 24 July 2015.

Before the inspection, we asked the provider to complete a Provider Information Return (PIR). This 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.

We spoke with nine of the 84 people using the service at the time of our inspection, relatives of three of those people and relatives of six other people. We looked at six people's care plans and associated records and 18 people's medication records. We spoke with the regional director, the registered manager, clinical nursing lead, a senior care worker, three care workers and a member of domestic staff.

We looked at a staff recruitment file, training plans and records associated with the provider's quality assurance system for monitoring and assessing the service.

We spoke with the local authority that funded some of the care of people using the service.

Requires improvement

Is the service safe?

Our findings

People using the service told us they felt safe. A person told us, "I am completely and utterly safe." They added that they were at risk of falls and that staff regularly checked that they were comfortable. Other people told us they felt safe because staff cared for them and because their rooms and communal areas were comfortable. Relatives of people using the service told us people were safe. They elaborated that their spouses or relations were safe because their days were planned and had fixed routines that provided a sense of security. A relative told us, "[The person using the service] is a lot safer here than at home" and another said, "We have no worries about [the person] being here."

Several people using the service spent all their time in their bedrooms, mostly in bed. When we walked around the service we noticed that most of those people's bedroom doors were open. A relative reported to us before our inspection that a person often walked into their relative's bedroom and had frightened the occupant of the room. During our inspection a person using the service and their relatives told us that one person in particular frequently came into their room uninvited, but they had not felt under threat because of that. Another person told us their relative was "not bothered by people who wander into his room." We did see three people walking along corridors past occupied bedrooms with open doors but did not see anybody entering other people's rooms. However on all three occasions we did not see any staff members in the corridors which meant there was a risk people could enter other people's rooms uninvited.

Relatives of people using the service we spoke with told us they were aware that some people presented behaviours that challenged others. Some told us that this had not given them cause for concerns about the safety of their relatives, but others were concerned. One told us a person using the service had walked into their relative's room and they themselves had been hit on three occasions by the person whilst in their relative's room. The provider had taken appropriate action in relation to the relative's concerns but this was potentially a wider issue affecting other people using the service and visitors for the provider to address.

We noted that signage on several bedroom doors was unclear because labels were either torn or illegible. It is possible this made it difficult for people to orientate and may have been a contributing factor to people walking into other people's bedrooms.

Since our last inspection in July 2014 the service had reported 18 reported incidents involving people using the service. People had been hit, punched, slapped, pushed or had objects thrown at them by other people using the service. Twenty people were involved in those incidents; seven as `perpetrators' and 13 were reported as `victims'. The registered manager and nursing staff had involved specialist health services to determine why some people demonstrated behaviour that challenged others and the number of incidents had gradually reduced after peaking in January 2015. The provider had therefore taken action to try to keep people safe from harm.

We noted that none of the nurses working at the service were mental health nurses. We were told that the regional director and registered manager were in discussions with the provider's human resources department about either recruitment of mental health nurses or accredited training in mental health for the existing nurses because it was felt that this would improve the care and support of the people living with mental health at Charnwood Oaks.

People's care plans included risk assessments associated with people's care routines. This meant care workers had access to information about how to support people safely. Where appropriate care plans also contained information about people's behaviour and possible triggers to behaviour that challenged others. This meant that staff had information about how to protect people from harming themselves and others by making timely interventions. The number of incidents where a person had hit or pushed another was high and showed that timely interventions were not always made by staff. The provider had taken action to improve the situation and the number of such incidents had reduced. Only one person we spoke with was concerned about the safety of their relative in the context of other people's behaviour. They told us, "I have no worries about the quality of care but I worry about other residents frightening my [person using the service].

Requires improvement

Is the service safe?

In the 12 months to the date of our inspection there had been a fall in the number of safeguarding incidents. Whilst there was a risk that a person could be harmed or distressed by another's behaviour that challenged, the risk had statistically reduced.

Staff we spoke with knew how to recognise signs of abuse. They were attentive to signs of unexplained bruising, changes in mood or behaviour and eating habits. They knew about the provider's procedures for reporting abuse either to a colleague or a senior. They were confident their concerns would be taken seriously. They were also aware of the provider's whistleblowing procedures which encouraged staff to report safeguarding concerns anonymously using a whistle blowing call-line. We saw posters about whistleblowing displayed in corridors. Nearly all staff had received safeguarding training.

Staff we spoke with told us that safeguarding was promoted at staff meetings. One told us they had reported a colleague because they had concerns about their practice. They told us they felt supported by the management during this process and were sure that they had done the right thing.

The provider had procedures for reporting and investigating accidents and incidents. The registered manager cooperated with the local authority safeguarding team when they carried out investigations at the service. That cooperation extended to working with the local authority to achieve improvements in safety of people using the service.

The provider had arrangements for the maintenance of equipment and monitoring the safety of the premises. Equipment such as hoists and stand-aids was serviced and maintained but we saw three wheelchairs with signs of wear and tear that were being used. One wheelchair was stained and an armrest was torn exposing the foam which was a potential infection control issue and the other armrest had no protective covering which could cause injury. The results of a satisfaction survey carried out in January 2015 recorded that people had said that `wheelchairs are sometimes dirty'. Our observations and the provider's survey therefore highlighted the same shortfall in maintenance of some equipment.

We found that two store rooms that should have been locked were not locked. One contained fluids and another had a rack that was overloaded and unstable. Either of those rooms could have been entered by people who liked walking along corridors. We saw several people walking unsupervised in those corridors. The rooms were locked only after we brought the matter to a nurse's attention. At a previous inspection we also found that storage rooms were not locked. After that inspection the provider told us that key pad locks would be fitted to storage room doors, but this had not happened. A fire door which had a sign clearly stating `please make sure the door is shut at all times' was propped open by a hoist. This doorway led to stairs to go to the ground floor. We saw people walking in the vicinity without staff supervision. The door was closed only after we brought the matter to the attention of a nurse. None of these matters posed an immediate risk but they highlighted a lack of attention to detail in terms of ensuring the premises were always safe and free of potential hazards to people's safety.

Staffing levels at the service were determined by the registered manager. They used a method that took into account people's needs and the level of support they required. Relatives of people using the service told us they felt enough staff were on duty. Some added that staff appeared to be very busy at times. A relative told us, "I wish staff had time to talk to [person using service] more" but others said that they saw staff spend time talking with people. We saw staff do that on both days of our inspection. One relative told us, "We can always find staff to talk to" and that was our experience too. Staff we spoke with had mixed views about whether enough staff were on duty. Most said there were, but on days an activities co-ordinator did not work they felt they did not have time to support people with meaningful activities. On the second day of our inspection, when the activities coordinator was not working we saw staff trying to encourage people to take part in drawing activities.

We found that enough staff were on duty but that more thought could be given to staff deployment to ensure that people who liked to walk around the home could do so safely without risk to themselves or others. We also found that no staff were on duty who could speak the same language as a person using the service. We witnessed that person trying to make themselves understood to two staff who responded by offering suggestions about what they thought the person was asking for. We were able to communicate with the person who indicated that they were comfortable and that their needs had been met. The

Requires improvement

Is the service safe?

provider does employ staff who speak the person's language, but none were on duty during our inspection. This showed that staff with the right mix of skills and knowledge were not always on duty.

People we spoke with told us they received their medicines on time. A person told us, "I get my medicines on time and the staff tell me what the medicines are for." A relative of a person using the service told us, "[person using service] gets their medicines when they need them. That is so important to us; it takes a weight of our minds." The provider's medications management policy was based on the latest guidance about medicines management. Medicines were stored safely and there were effective arrangements for the disposal of medicines that were no longer required. Only staff who were trained to give people their medicines did so and their competencies to continue to do so were regularly assessed.

The senior care worker responsible for administration on the day of the inspection told us that they had attended training on medicines management and had been competency assessed. They described the principles of safe administration which showed they understood the provider's policy. We observed part of a medicines round and saw that staff followed the correct practice. They explained to people what their medicines were for and observed that the medicines were taken before moving on to the next person. Records of medicines administration were only completed after a person had their medicines. If a person refused their medication this was recorded.

A person had a covert medicines plan. The plan stated that this was only to be used as a last resort. Records we looked at showed that this option had only been necessary on four occasions out of 26 administrations. This showed that staff followed people's medicine plans.

Requires improvement

Is the service effective?

Our findings

At our last inspection we found that not all staff had not been supported to be able to support people who at times displayed behaviour that challenged others. We saw some staff failed to respond effectively when some people presented verbally challenging behaviour despite having attended training about how to support people in those circumstances. We found this to be a breach of Regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which following the legislative changes of 1st April 2015 corresponds to Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we found that the provider had taken action to improve the quality of training staff received to be able to support people when they presented challenging behaviours. The training was provided by an external specialist and the effectiveness of the training had been evaluated. We saw that permanent staff responded appropriately, safely and effectively when presented with behaviour that challenged. A care worker we spoke with told us that they'd found that training particularly helpful. They said, "The training totally made me rethink my responses to [to people using the service]." A relative told us that staff coped very well when their relative said things like "I want to go home." This kind of scenario had been covered in training. We saw only one lapse in that regard from a bank member of staff who made no response when a person using the service asked several times, "Are you my daughter?"

Another bank worker told us they had not received training in how to support people who at times demonstrated behaviour that challenged others. We brought that to the attention of the registered manager who told us that bank staff had not yet had the training that permanent staff had received but that training was scheduled for dates after our inspection.

Most staff communicated with the people using different ways of communication, for example by touch, gesture and speech. They positioned themselves at eye level with people they communicated with and altered the tone of their voice appropriately. We saw two exceptions to this. One care worker spoke to a person very loudly and in a commanding tone telling a person to sit down. This could be heard down the corridor. Later we heard a care worker responding very loudly in English to a person who was speaking another language. The care worker kept asking in English what the person wanted before understanding that the person wanted a drink of water. Throughout the conversation the carer spoke loudly and close to the person's face whilst the person using the service spoke their language. We were told later that the person understood and spoke English, but the conversation we witnessed were not a good display of communication skills. Our observations illustrated that some staff lacked effective communication skills.

People using the service told us they felt that staff had the necessary skills and knowledge to support them with their needs. A person told us, "The staff are wonderful people, I'm brilliantly looked after." Another told us, "The staff are skilled, some more than others." Relatives told us they felt that most staff had the necessary skills. One told us, "Some staff are so good, but some are better than others." Other relatives said similar things. Their comments included, "The care varies. It depends which carers are on duty" and "The staff are very good, but some are better than others." People did not identify which staff were better than others. One reason was that staff did not wear name badges. This frustrated one relative who told us staff knew who they were but they didn't know staff's names.

Staff we spoke with told us they felt some staff lacked skills. One said, "Some staff know how to deal with challenging behaviour, others don't." A senior told us, "The majority of staff are skilled but some don't employ the proper tactics." They added that they provided focused help to staff they felt had not put training into practice. Our own observations were that some staff were more skilled than others.

We spoke with staff who were relatively new to the service. They recalled what they described as a tough and demanding recruitment process during which they felt their suitability to work at Charnwood Oaks was thoroughly tested. One told us, "I had a tough interview when I was asked lots of questions." We looked at a recruitment file and saw evidence of a robust recruitment process. People using the service could be confident that the provider tried to ensure as far as possible that only suitable staff were employed at Charnwood Oaks.

Staff were supported by their line managers through regular meetings, called `supervision meetings', where their performance and training needs were discussed. In

Requires improvement

Is the service effective?

addition, specific individual topics were discussed to support staff with learning and development. For example, topics such as supporting people with their mobility were discussed. We saw that other topics, such as consent to care and supporting people with behaviour that challenged others, were scheduled to be discussed. The provider had a requirement for staff to have six supervision meetings each year. Records we looked at showed this had been almost achieved for permanent staff but not all bank staff had supervision meetings. The registered manager had themselves identified that not all bank staff had supervision meetings and had taken action to address this by scheduling supervision meetings.

Staff we spoke with understood the requirements of the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS). MCA and DoLS is legislation that protects people who lack mental capacity to make decisions about their care and who are or may become deprived of their liberty through the use of restraint, restriction of movement and control. Any restrictions must be authorised by a local authority. Where people were under a DoLS authorisation the staff complied with the conditions. The provider had effective procedures for ensuring that authorisations were reviewed before they expired which meant that no people were under any restrictions without them being properly authorised. Staff we spoke with told us the training they had about MCA and DoLS was helpful.

We saw that staff sought people's consent before they provided care and support. A person told us, "Staff ask me if I want a shave." We heard and saw staff using language and gestures to ask if a person wanted support and only proceeded to provide it after the person consented. We heard and observed staff seek consent from people when they required support with personal care. Where people lacked capacity to give consent staff acted in their best interests and in line with the MCA Code of Practice.

People using the service told us they enjoyed the meals at Charnwood Oaks. They told us they were asked what they wanted for lunch. During the morning we heard staff telling people what meals were available and asking them what they wanted. People were able to choose from a variety of meals, for example on the day of our inspection the main meal choice was chicken casserole or roast pork but people could have salads or other meals that were made to order. Information about people's choices was passed to the cook and kitchen staff who prepared meals according to people's choices. The cook and kitchen staff were aware of people's nutritional needs and food preferences. They knew which people required food to be served in pureed form, which people were vegetarians and which people needed to have the meals fortified. People's care plans contained information about people's dietary and nutritional needs.

The provider had procedures in place for staff to monitor people's nutritional health. This included regularly weighing people and acting on any unplanned weight loss, for example by arranging for peoples doctors and dieticians to be involved in their care. We saw evidence that this had happened. However, there were two instances where staff were slow to make referrals and in one case only did so when relatives insisted they did so.

We observed a meal time. We saw that meals were served hot. People who required support with meals received appropriate support. However, we saw that a person had fallen asleep during their meal. They had been served with a bowl of soup with bread broken into it. By the time the person awoke the soup had was cold. The provider's procedures require staff to offer to reheat meals in such circumstances but staff made no attempt to do this until we intervened and asked them to.

Most people and relatives we spoke with told us that they felt their everyday health needs were met. A person described their care as being brilliant. Relatives told us staff telephoned a person's GP if the person was unwell. A relative told us, "The nursing care is really good." Most relatives felt the quality of everyday day was good but they added that it often depended on which staff were on duty. We saw evidence in people's care records that they had been referred quickly to health services when they needed them, for example to a GP, a dietician and chiropodist. However, there were two instances where staff were slow to make referrals and in one case only did so when relatives insisted they did so. The provider's own audit of how people's nutritional care was delivered identified delays in referrals to a dietician. In one person's nutritional care plan entries of `chase up dietician referral' had been made over a period of six months which showed that whilst there was a well-intentioned aim to support a person's nutritional health, practical action had not been taken.

Good

Is the service caring?

Our findings

People using the service told us they were treated with kindness by staff. A person referred to care workers as "wonderful people." Another told us, "The staff are very nice indeed." Relatives also spoke favourably about staff. One said, "The staff are marvellous, they are so patient."

The provider promoted dignity in care through staff training and posters throughout the home. At the time of our inspection only half of the staff working in the four residential units at Charnwood Oaks had attended the training. The remainder were due to attend training on 12 and 19 August 2015. This explained why some relatives felt some staff were better than others and why the results of the latest satisfaction survey recorded that 'generally speaking the care staff are kind, well intentioned and respectful and most are exceptionally good and sensitive.'

The provider had procedures for finding out what was important to people and for staff to act on the information. Care plans we looked at had a section called `getting to know you' which was intended to support staff to understand what mattered to people so that they could provide care that met people's needs.

We saw examples of staff being kind and compassionate. We saw staff providing people with reassurance when they displayed signs of anxiety. Staff held people by the hand when they talked with them to show they cared. They helped people feel they mattered by supporting them to do things that were important to them and praising their efforts. For example, one person told us it was important to them that they could garden and staff supported them to do that. We heard staff say, "You are doing wonders in that garden." We saw and heard staff offering people choices about what they wanted to do and respecting their choices. Most staff explained to people how they were going to support them, for example how to sit comfortably. We saw an excellent example of a member of staff, a cleaner, engage in meaningful conversation with a person who clearly enjoyed the experience. We spoke with the cleaner who told us, "I make time to talk with people when I clean their room. It's what they want. I always ask if there is something I can do for them."

However, we also saw four examples of a very small number of staff not displaying kindness and compassion. We heard a bank care worker command a person to sit down and telling people what to do rather than asking them what they wanted to do. Later, the care worker supported a person into a wheelchair and took them out of a lounge without explaining where they were going. When they returned the person was left in the middle of the lounge without explanation. We saw another care worker tell a person they would take them to the dining room for lunch but then they walked away leaving the person. In another location we saw a care worker provide a person with a glass of water which they placed out of the person's reach. We had to intervene to place the drink within the person's reach. These were isolated instances that were outweighed many more examples of kind and compassionate care.

Most staff gave explanations to people about how they were going to support them. We saw two contrasting examples in the same lounge at the same time. A person asked if they could go out for to smoke a cigarette. A care worker told them, "Sit down whilst I get a light (cigarette lighter)" and left the person. At the same time another person made a similar request to another care worker who responded, "I'll need to get you a lighter. Would you like a coffee whilst you wait and I'll bring it to you." They gave the person a cup of coffee and went away for a short while before returning with a cigarette lighter and assisted the person to a smoking area. Meanwhile, the other care worker returned and called out in a loud voice, "Here's your lighter." Most staff we observed and heard were discreet when people needed assistance. They reassured people who were anxious and distressed and managed several difficult situations in the communal lounge calmly and sensitively.

People we spoke with told us they felt involved in decisions about their care. A person told us, "I feel involved and listened to, that's important to me." People told us they were asked about what was important to them and what they liked, for example about what food they liked and the types of activities they enjoyed. Two people who had been using the service for a relatively short time and their relatives told us they had been involved in discussions about how their rooms could be personalised to make them more comfortable. Both told us it was important to them that their rooms were `homely'. The provider's monitoring of the service had identified a need to improve the ambience of people's rooms and involved people and relatives in discussions about how that could be achieved.

Good

Is the service caring?

Relatives of people using the service told us they felt involved. One told us, "I was very much involved when [person using the service] needs were assessed. I was very pleased with that." Another relative also told us they felt very involved and said that they were provided with "lots of information about the service" when their relative's needs were assessed. They added that they were involved in reviews of their relatives care plan. They were particularly pleased because they were told by the registered manager that "anything was possible" in terms of making their relative feel comfortable in their room. That was important to the relative because being in comfortable surroundings was something that mattered a lot to the person using the service. They said of the support from the provider, "It's taken a weight of our shoulders."

Two sets relatives told us before our inspection that they felt they had not been informed promptly about things they felt they should have been informed about. They told us they had not been informed about serious deteriorations in their relative's health. During our visit, relatives told us they had been kept informed of changes in their relative's health and when they had experienced falls or injuries. Shortly before our inspection the provider reviewed their arrangements for keeping relatives informed. New procedures were put in place to ensure that staff knew who to contact to keep them informed about their relatives.

Staff respected people's privacy. We observed staff knock doors before entering people's rooms. Signs were used to indicate that people were receiving personal care requesting that people did not enter the rooms at those times. Most bedrooms doors were open including in rooms where people were in bed. This was to facilitate observations of people to see that they were safe or in need of assistance, but this also compromised their privacy. Two relatives told us that whilst they were not anxious about people walking `wandering' into their relative's rooms they did not think it was an ideal situation. One relative told us, "I'm not bothered by people wandering", and another told us their relative had been "frightened" on occasions when other people using the service came into their room. They added they had had discussed their concern with the provider and that staff had kept their relatives bedroom door closed.

Our observations were that whilst most staff displayed kindness and compassion, a very small number did not. The lapses we saw occurred in the same location and at the same time that we saw other staff display more caring behaviour towards people using the service. This confirmed what relatives told us about the variation in skills and abilities of care workers. Our observations of less skilled care were isolated to one of the four units at Charnwood Oaks. We discussed this with the registered manager and regional director who told us that the individuals we discussed would receive additional personal training and support.

Good

Is the service responsive?

Our findings

People using the service who were able to, contributed to the assessment of their needs and planning of care. A person told us that shortly after they began to use the service they asked if they could see a podiatrist regularly and that had been incorporated into the person's care plan. Two people using the service and their relatives told us that they had been involved in decisions about the decoration and furnishing of their bedrooms. A person told us the provider had arranged for them to have their favourite armchair from home to be put in their bedroom at Charnwood Oaks.

When people's needs were assessed and reviewed at regular intervals, they and their relatives were asked about what was important to them. This was most evident in terms of people's interests and hobbies. We spoke with one person who told us that it was very important to them that they could garden. Charnwood Oaks had a landscaped garden and the person was supported to spend time working in it. We saw the person gardening when we arrived for our inspection and because of how enthusiastic they appeared to be we thought it was a professional gardener before we were told it was a person using the service. Another person enjoyed watching wildlife and birds. Staff provided them with birdfeeders outside their room so that they could watch birds. The person told us how much they enjoyed doing that. They added that staff knew which radio programmes they liked to listen to and helped tune the radios to those programmes. A cleaner we spoke with told us they knew what TV and radio programmes people enjoyed and when she cleaned people's rooms she asked if they wanted to watch or listen to those programmes. We heard that to be the case when we walked past people's bedrooms when the cleaner was there.

The service had a part-time activities co-ordinator who organised activities for people using the service. These included group activities for several people and one to one activities. We observed a group activity that was attended by five people. The session included a broad range of stimulating and meaningful activities and discussions that allowed all people to participate. We spoke with one of the people who attended and they told us they enjoyed the session. The activities coordinator also spent one to one time with people supporting them with activities which included discussions and providing people with their favourite music to listen to. Care staff also supported people with activities, including on days the activities coordinator did not work. We saw care staff and housekeeping staff spend time having conversations with people, helping them read newspapers and magazines, do puzzles and colouring. Relatives we spoke with told us that one of the most important things people using the service needed was meaningful conversation and they acknowledged that staff did their best to provide that. A relative's comment that, "I wish they (staff) had more time to talk to [person using service]" was representative of what other relatives told us.

At the time of our inspection the provider was in the processing of purchasing `memory boxes' and tactile objects for people to use. This was in line with recommendations made by charities that specialised in dementia care and support for people with sensory disabilities.

People's care plans included details of the assessments of their individual needs and information for nurses and care staff about to meet those needs. Care plans included information about people's life histories and interests which was used by the activities coordinator to design suitable and meaningful activities for people. Activities included outings to places of interest and social activities such as birthdays and other celebrations. Some people using the service liked dogs and staff supported people with that interest by bringing dogs to Charnwood Oaks. Relatives with pets were allowed to bring them when they visited. People took dogs for walks with staff. A relative told us "[Person using service] is really happy he can walk dogs. The staff have gone the extra mile with that."

People's care plans included information about how they should be supported with their needs, for example with personal care and how their health should be monitored. Care records we looked at showed that people's health was regularly monitored and that changes to care plans were made to reflect changes in people's circumstances. Care plans were regularly reviewed, often with relatives being involved. A relative told us they were listened to when they suggested at a review that their relative's medications should be reviewed. Shortly before our inspection the provider introduced new procedures to invite all relatives to reviews of people's care plans.

Good

Is the service responsive?

Care plans had sections about how people should be protected from social isolation. The provider's procedures required staff to record what activities a person had been involved in socially so that potential risks of social isolation could be identified. In a care plan we looked at we saw records to the effect that a person had been encouraged to participate more in activities they said they liked. We spoke with their relative who confirmed that staff had helped their relative avoid social isolation. They said, "The staff look after [person using service] very well." We saw staff spend time talking with the person in a communal lounge.

Care plans were regularly evaluated by nurses. We saw evidence that reviews resulted in adjustments to people's delivery of care. This showed that reviews were focused on people's needs and not a routine task orientated activity.

People had information available to them about how to make complaints. Relatives we spoke with told us they knew how to make complaints or raise concerns. Relatives who had raised concerns told us that they had been listened to and that their concerns had been acted upon. A relative told us that a minor barrier to raising an issue or concern with staff was that they did not know staff names because staff did not wear name badges. The relative summed up their feeling about this by saying, "I've told staff `you know me but I don't know you'." We were told that it was the provider's policy for staff not to wear name badges. The same issue had been highlighted at other services run by the provider.

People using the service and relatives were able to provide feedback using a comments book, at reviews of care plans and through satisfaction surveys. People using the service and relatives told us they had participated in the satisfaction survey.

The provider had procedures for staff to report concerns about delivery of care or incidents and accidents. Staff we spoke with were familiar with those procedures. Reports were investigated by senior care workers, nurses and senior management. Complaints were investigated by the regional director and the provider's managing director. We saw that changes to procedures had been made in light of findings from investigations of reports of concern and complaints. Other responses to feedback included additional training and support for staff and, where necessary, disciplinary action.

Good

Is the service well-led?

Our findings

People using the service and their relatives did not tell us directly that they felt involved in developing the service. However, they felt involved in decisions about the delivery or care and said that their suggestions and requests had been acted upon. For example, people were provided with what they needed to maintain hobbies and interests that were important to them. People told us they were asked for their views about the service. They told us they had participated in satisfaction surveys which the provider carried out for the purpose of learning what people thought of the service. People's feedback from the survey was acted upon by the provider. For example, improvements were made to how staff kept families informed about their relatives and the range of activities offered to people was being improved.

Staff were supported to raise concerns they had about poor practice. They knew they could raise concerns through procedures that were in place for doing so. These included a whistle blowing procedure through which staff could raise concerns anonymously with senior people in the provider organisation. Staff knew they could raise concerns with their line managers at any time and at formal supervision meetings which included concerns as an agenda item. Staff we spoke with told us they had reported concerns about what they felt was poor practice by colleagues and that the provider had taken action in response to their concerns. Actions included providing people with further training and disciplinary action.

The registered manager, a clinical services manager (a nurse) and regional director (when they visited the service) `walked the floor' to observe care practice and monitor how staff supported and behaved towards people using the service. The clinical services manager told us, "I observe directly interactions and responsiveness of these staff to the residents as I go about my duties." We saw this in action and saw that they asked care staff questions why they supported people the way they had. Senior care workers who were team leaders told us about how they tried to ensure that care staff put their training into practice and that they offered additional mentoring to staff who needed it.

The service was organised into four care units each with a team leader reporting to the registered manager. Staff we spoke with understood the organisation of the service and people's roles in it. This meant that the leadership of the service was evident and visible to staff. The housekeeping keeping unit had a manager who was part of the management team which was important because one of that team's responsibilities was to ensure people using the service were supported with their nutritional needs. The management structure at Charnwood Oaks was understood by staff we spoke with.

The registered manager was aware of their responsibilities to ensure that inform us of events at the service such as unexpected deaths, serious injuries and allegations of abuse. This was important because it meant we were kept informed about events at the service and we could check whether appropriate action was taken in response to events. The registered manager told us, "I have trust in the team and I am confident they would alert me to any concerns. Staff we spoke with told us the registered manager was very approachable and accessible as was the clinical services manager.

The management team at Charnwood Oaks worked cooperatively with the local authority that paid for some people's care at the service to implement recommendations the local authority had made about improvements to the service. The management team had a shared understanding of the challenges facing the service and had action plans to address those challenges. The provider had arranged additional training for staff to help them to better support people who at times presented behaviour that challenged others. The provider also worked with specialist NHS healthcare providers to further develop care plans of people who presented behaviour that challenged others.

Permanent staff knew what was expected of them because they had regular supervision meetings, training and newsletters to keep them informed about the service and its aims. Staff we spoke with told us about improvements that were made to the service, primarily through focused training on areas they felt needed improving. Staff were involved in developing the service through supervision meetings and making suggestions. This was most evident in the types of activities that were introduced for people using the service.

The provider had quality assurance procedures that operated at two levels. At service level, the registered manager and clinical lead and team leaders carried out regular scheduled checks about the quality of care

Good

Is the service well-led?

provided. These were reported to the regional director who carried out their own checks, some of which were to verify what had been reported to them. We found the quality assurance procedures to be geared towards identifying areas that required improvement. Findings from internal investigations and from safeguarding investigations carried out by the local authority were used to identify and implement improvements.