Oaklands Care Hove Limited

Oaklands

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?	Requires improvement

Overall summary

This inspection took place on 13 October 2015 and was unannounced.

Oaklands is a nursing home for up to 22 people. It provided nursing care and personal support to adults but predominately older people with nursing care needs. At the time of our inspection there were 16 people living at the service. The service was in a large detached house, arranged over three floors accessed by a passenger lift. The ground and first floor was used to provide people with nursing care, support and treatment. Long term care and respite care was provided.

There was a registered manager for the service. 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. However, we have been subsequently notified that the registered manager has now left the service and a new manager was being recruited to the position.

Summary of findings

This was the first inspection carried out since the registration of a new provider for the service in April 2015. A new registered manager had been appointed and there had been a number of changes in the care team working in the service. The building was going through a period of refurbishment.

Quality assurance process were not fully in place to audit and quality assure the care provided. Where quality assurance audits had been completed these had not all been maintained or fully embedded in the running of the service. This meant there was limited information available as to how the service was improving following feedback received. This was an area in need of improvement.

Staff demonstrated an awareness of the Mental Capacity Act (2005) (MCA) and of the need for people to consent to their care and treatment. Not all of the Do Not Resuscitate (DNAR) forms had a review requested where needed to ensure the information was still up-to-date. This was an area in need of improvement.

The Care Quality Commission (CQC) is required by law to monitor the operation of the Deprivation of Liberty Safeguards. Staff had policies and procedures to follow and demonstrated an awareness of where to get support and guidance when making a DoLS application. Although a number of applications had been made for one person the use of bedrails had been omitted as part of the application. For another person there was no documentary evidence as to how conditions in place were being met. This was an area in need of improvement.

People had individual assessments of potential risks to their health and welfare, which had been regularly reviewed. However, the recording of checks completed had not been consistently recorded to inform the care staff of the care to be provided. This was an area in need of improvement.

Where people were being supported with wound care detailed treatment plans were not in place to fully protect people. This was an area in need of improvement.

There was a maintenance programme in place which ensured repairs were carried out in a timely way. However, there was not a copy of a current electrical wiring certificate. This was an area in need of improvement. There were areas where the décor and furnishings was in need of updating to improve the environment people lived in. However, there was a refurbishment plan in place to improve the environment in which people lived. There was an emergency on call rota of senior staff available for help and support. However, contingency plans were not in place to respond to any emergencies such as flood or fire. This was an area in need of improvement.

Medicines were stored correctly and there were systems to manage medicine safely, audits and stock checks were completed to ensure people received their medicines as prescribed.

People's individual care and support needs were assessed before they moved into the service. Care and support provided was personalised and based on the identified needs of each individual. People's care and support plans and risk assessments were detailed and reviewed regularly giving clear guidance for care staff to follow. People's healthcare needs were monitored and they had access to health care professionals when they needed to.

People told us they felt safe. They knew who they could talk with if they had any concerns. They felt it was somewhere where they could raise concerns and they would be listened to. People were treated with respect and dignity by the staff. They were spoken with and supported in a sensitive, respectful and professional manner. One person told us, "I am so lucky to be in such a nice place, with a large room overlooking a sea view." One relative told us it was,"Home from home."

People said the food was good and plentiful. One relative told us the food was, "Absolutely brilliant. All homemade and they select their choice each morning." Staff told us that an individual's dietary requirements formed part of their pre-admission assessment and people were regularly consulted about their food preferences.

Senior staff monitored people's dependency in relation to the level of staffing needed to ensure people's care and support needs were met. Staff told us they were supported to develop their skills and knowledge by receiving training which helped them to carry out their roles and responsibilities effectively. Training records were kept up-to-date, plans were in place to promote

Summary of findings

good practice and develop the knowledge and skills of staff. One relative told us, “Staff are absolutely brilliant. There is some really nice staff and they all work together as a team.”

People were cared for by staff who had been recruited through safe procedures. Recruitment checks such as a criminal records check and two written references had been received prior to new staff working in the service.

Staff told us that communication throughout the service was good and included comprehensive handovers at the beginning of each shift and regular staff meetings. They confirmed that they felt valued and supported by the managers, who they described as very approachable.

People and their representatives were asked to complete a satisfaction questionnaire, and people had the opportunity to attend residents meetings. We could see the actions which had been completed following the comments received. The registered manager also told us that they operated an 'open door policy' so people living in the service, staff and visitors could discuss any issues they may have.

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?

The service was not consistently safe. People had individual assessments of potential risks to their health and welfare, which had been regularly reviewed. However, the recording of checks completed had not been consistently recorded.

There was an improvement plan to improve the environment people lived in. However, contingency plans were not in place to respond to any emergencies such as flood or fire.

People were cared for by staff who had been recruited through safe procedures. There were sufficient staff numbers to meet people's personal care needs.

Requires improvement

Is the service effective?

The service was not consistently effective. Staff were aware of the Mental capacity Act (2005) and the Deprivation of Liberty Safeguards (DoLS.) However, there were areas of practice which did not meet current guidance.

Where people were being supported with wound care detailed treatment plans were not in place to protect people.

Staff had a good understanding of people's care and support needs. People were supported by staff that had the necessary skills and knowledge.

People were able to make decisions about what they wanted to eat and drink and were supported to stay healthy. They had access to health care professionals when they needed.

Requires improvement

Is the service caring?

The service was caring. Staff involved and treated people with compassion, kindness, dignity and respect.

People were treated as individuals. People were asked regularly about their individual preferences and checks were carried out to make sure they were receiving the care and support they needed.

People told us care staff provided care that ensured their privacy and dignity was respected.

Good

Is the service responsive?

The service was responsive. People had been assessed and their care and support needs identified. Care plans were in place to ensure people received care which was personalised to meet their needs, wishes and aspirations.

Good

Summary of findings

People were supported to take part in a range of recreational activities. These were organised in line with peoples' preferences. Family members and friends continued to play an important role and people spent time with them.

People were comfortable talking with the staff, and told us they knew who to speak to if they had any concerns.

Is the service well-led?

Requires improvement

The service was not consistently well led. Quality assurance was used to monitor to help improve standards of service delivery. However, this had not been consistently maintained or embedded in the service.

The leadership and management promoted a caring and inclusive culture. People, relatives and staff told us the management and leadership of the service was approachable and very supportive.

People were able to comment on and be involved with the service provided to influence service delivery.

Oaklands

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 checked 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 13 October 2015 and was unannounced.

The inspection team consisted of two inspectors and a specialist advisor. Before the inspection, we reviewed information we held about the service. This included any notifications, (A notification is information about important events which the service is required to send us by law) and complaints we have received. This helped us to plan our inspection. We requested 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 telephoned the local authority commissioning team, who have responsibility for monitoring the quality and safety of the service provided to local authority funded people. From this information, following our visit, we contacted two health care professionals to ask them about their experiences of the service provided.

We could not speak to all the people due to their care needs. But we spoke with seven people, and three visitors who were friends or relatives. We spoke with the registered manager, a registered general nurse (RGN), a senior care worker, the activity co-ordinator, a chef and the maintenance person. We observed the care and support provided in the communal areas, and the mealtime experience for people over lunchtime living on the ground floor.

We looked around the service in general including the communal areas, people's bedrooms, and the garden. As part of our inspection we looked in detail at the care provided to five people, and we reviewed their care and support plans. We looked at menus and records of meals provided, medicines administration records, the compliments and complaints log, incident and accidents records, records for the maintenance and testing of the building and equipment, policies and procedures, meeting minutes, staff training records and two staff recruitment records. We also looked at the provider's own improvement plan and quality assurance audits.

Requires improvement

Is the service safe?

Our findings

People and their visitors told us they felt people were safe, happy and were well treated in Oaklands. One person told us when asked if they felt safe in the service, "Yes, when I was at home I was on my own. Here I have lots of people and I feel very safe." However, we found areas of practice which were in need of improvement.

People had individual assessments of potential risks to their health and welfare and these were reviewed regularly. Where risks were identified, staff were given clear guidance about how these should be managed. Staff also told us if they noticed changes in people's care needs, they would report these to one of the managers and a risk assessment would be reviewed or completed. People had an air mattress (inflatable mattress which could protect people from the risk of pressure damage) where they had been assessed as high risk of skin breakdown (pressure sore). We were informed by the registered manager that air mattresses were checked daily to ensure they were on the right setting for the individual needs of the person. Records we looked at confirmed this However, in one instance we found that the air mattress setting was not set at the setting detailed in the person's care plan. This could have potentially placed them at risk of skin damage or developing pressure sores. We discussed this with the registered manager during the inspection who told us this would be rectified. Where people had been assessed as requiring to be turned periodically during the day not all the recording had been completed to demonstrate this had been done and inform the staff team of people's care needs. This was an area in need of improvement.

We looked around the building and found there were a number of areas in need of redecoration and equipment and furnishings in need of replacement to improve the physical environment in which people lived. We discussed this with the registered manager during the inspection who confirmed that they were aware of the work to be completed. They had an action plan to make improvements to the physical environment. They told us of the changes which had already been made, for example redecoration of people's bedrooms and new equipment purchased. Also of further work planned to be carried out, for example the upgrading of a communal shower. Relatives we spoke with confirmed there had been improvements made to the environment and were aware of the changes and further improvements planned to be made. Staff told us equipment had been regularly checked and serviced. Regular tests and checks were completed on essential safety equipment such as emergency lighting, the fire alarm system and fire extinguishers. Records we looked at confirmed this. However, there was not a copy of a current electrical wiring certificate. This was an area in need of improvement..

A dedicated maintenance worker was responsible for the general maintenance. Staff we spoke with confirmed that any faults were repaired promptly, and records confirmed this. The registered manager told us about the regular checks and audits which had been completed in relation to fire, health and safety and infection control. There was an emergency on call rota of senior staff available for help and support. However, contingency plans were not in place to respond to any emergencies such as flood or fire. This was an area in need of improvement.

We looked at the management of medicines. The registered manager described how they completed the medication administration records (MAR). MAR charts are the formal record of administration of medicine within a care setting and we found these had been fully completed. Medicines were stored correctly and there were systems to manage medicine safely. Regular audits and stock checks were completed to ensure people received their medicines as prescribed. Where people took medicines on an 'as and when' basis (PRN) there was guidance in place for staff to follow to ensure this was administered correctly. Where people had topical creams applied recording had been completed to evidence it had been applied and inform other care staff.

The provider had a number of policies and procedures to ensure care staff had guidance about how to respect people's rights and keep them safe from harm. These had been reviewed to ensure current guidance and advice had been considered. This included clear systems on protecting people from abuse. Staff had received an update of these at a recent staff meeting. The registered manager told us they were aware of and followed the local multi-agency policies and procedures for the protection of adults. They were aware they had to notify the CQC when safeguarding issues had arisen at the service in line with registration requirements, and therefore we could monitor that all appropriate action had been taken to safeguard people from harm. One member of staff told us they were aware of

Requires improvement

Is the service safe?

these policies and procedures and knew where they could read the safeguarding procedures. We talked with care staff about how they would raise concerns of any risks to people and poor practice in the service. They had received safeguarding training and were clear about their role and responsibilities and how to identify, prevent and report abuse.

There was a whistle blowing policy in place. Whistle blowing is where a member of staff can report concerns to a senior manager in the organisation, or directly to external organisations. The care staff we spoke with had a clear understanding of their responsibility around reporting poor practice, for example where abuse was suspected. They also knew about the whistle blowing process and that they could contact senior managers or outside agencies if they had any concerns.

Accidents and incidents were recorded and staff knew how and where to record the information. Remedial action was taken and any learning outcomes were logged. Steps were then taken to prevent similar events from happening in the future.

People told us staff were always very busy, but there were always staff available to help them with their care. One person told us, "Yes, they help me with whatever I need. I am here because my diabetes couldn't be managed, staff have helped me." Another person told us when asked if there were enough staff, "Everything is to my liking." There were adequate numbers of staff on duty to meet the needs of people living in the service. The registered manager told us there had been a period of change with a number of new care staff being recruited into the service. Care staff were supported by the ancillary staff who covered catering, domestic, maintenance and administrative tasks in the service. On the day of the inspection there was only one permanent member of care staff on duty with three agency staff. The registered manager told us this was due to staff leave and sickness and that agency staff who had worked in the service previously had been requested to provide cover. The registered manager was also the registered general nurse (RGN) on duty for the morning. She demonstrated she knew the people well. They did not use a dependency tool to help ensure that there were adequate staff planned to be on duty. However, they regularly worked in the service met with the RGNs and they used their knowledge of peoples care needs to identify the level of staffing needed. The service was staffed to full occupancy due to the high care needs of the people. Staff told us that at times it could be busy, but there was adequate staff on duty to meet people's care needs. They told us minimum staffing levels were maintained. They also spoke of good team spirit. People and visitors told us there were enough staff on duty to meet people's needs. Staff had time to spend talking with people and supported them in an unrushed manner. All rooms had call bells to enable people to summon assistance. Bedrooms included an emergency call bell which people could press if they required urgent attention and a call bell to press if they required assistance. We found that call bells were answered promptly by staff on the days of the inspection. People told us when they called for assistance they received help in a timely way. A sample of the records we looked at showed that the minimum staffing level was adhered to.

People were cared for by staff who had been recruited through safe recruitment procedures. Where staff had applied to work at Oaklands they had completed an application form and attended an interview. Each member of staff had undergone a criminal records check and had two written reference requested. Where registered nurses were being recruited we saw that checks had been made on their pin number. This is an information system which can be accessed to ensure nursing staff were still registered to work as a nurse provided nursing care. This meant that all the information required had been available for a decision to be made as to the suitability of a person to work with adults.

Requires improvement

Is the service effective?

Our findings

People and the visitors told us they felt the care was good. One relative told us it had been a great relief for them that their relative was so well cared for. “He seems happy here, and I take him home occasionally.” However, we found areas of practice which were in need of improvement.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. We checked whether the staff were working within the principles of the MCA. Staff understood the principles of the MCA. They were aware any decisions made for people who lacked capacity had to be in their best interests. They gave us examples of how they would follow appropriate procedures in practice. There were clear policies around the MCA. Care staff told us they had completed this training and all had a good understanding of the need for people to consent to any care or treatment to provided. There was records on people’s care plans that, where possible, people had been asked to consent to their care and treatment. However, where people had a Do Not Attempt Resuscitation (DNAR) form completed these had not all had a review requested where needed to ensure the information was still up-to-date. This was an area in need of improvement.

CQC is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLS). DoLS are the process to follow if a person has to be deprived of their liberty in order for them to receive the care and treatment they need. The registered manager told us they were aware how to make an application and about the three DoLS applications that had already been made and had been agreed. Care staff told us they had completed this training and had a good understanding of what this meant for people to have a DoLS application agreed, and they were clear who had been put forward for a DoLS application. People’s records also highlighted to care staff who had a DoLS in place, or if there were any actions they had to follow to support people where an application had been agreed. However, for one person there were conditions in place as part of the DoLS. We discussed this with the registered manager during the inspection who was able to explain how this person had been supported with these conditions, but there was no record as to how these conditions were being met. It was observed throughout the inspection that many people had bed rails in place. Under the Mental Capacity Act (MCA) 2005 Code of Practice, where people’s movement is restricted, this could be seen as restraint. Bed rails are implemented for people’s safety but do restrict movement. Bed rail risk assessments were in place for people where bed rails were used and where possible people had consented to their use. However, for one person this was not in place. We discussed this with the registered manager who told us this had been looked at as part of the DoLS in place. However, there was no record that this had been considered within the DoLS application. This is an area that needs to be improved.

There was a policy and procedure for care staff to follow for wound care. One of the registered nurses had also undertaken further training in wound care. Where one person was receiving wound care the registered manager told us about how the nursing team were managing this area. However, there was not a treatment plan for the wound for care staff to follow, nor recording or on-going photographic evidence to monitor and review how the wound was progressing with treatment. Effective monitoring systems to evaluate and ensure the person’s health and well-being was maintained in relation to this wound were not in place. This was an area in need of improvement.

It is recommended that current guidance be sought and implemented in the service.

People’s nutritional needs were assessed and recorded, and people’s likes and dislikes had been discussed as part of the admissions process. Records were accurately maintained to detail what people ate to inform staff if people had had adequate food and fluid during the day. Some people had food and fluid intake charts. They relied on care staff to ensure they had enough to eat and drink throughout the day. We found that these had been completed, however had not been totalled at the end of

Is the service effective?

the day. This did not ensure care staff had a clear and full picture of if people had received adequate fluids during the day to maintain their wellbeing. This is an area that needs to be improved.

People's weights were monitored regularly with people's permission and there were clear procedures in place regarding the actions to be taken if there were concerns about a person's weight. For example where a person had lost weight more frequent checks of their weight had been carried out and their diet reviewed and a fortified diet considered. One staff member told us, "If people are not eating well, we weigh them weekly to see if any weight has been gained. We assist them to eat or encourage them to eat and there are snacks available if losing weight."

People were supported by care staff that had the knowledge and skills to carry out their role and meet people's individual care and support needs. The registered manager told us all care staff completed an induction before they supported people. This had recently been reviewed to incorporate the requirements of the new care certificate. This is a set of standards for health and social care professionals, which gives everyone the confidence that workers have the same introductory skills, knowledge and behaviours to provide compassionate, safe and high quality care and support. There was a period of shadowing a more experienced staff member before new care staff started to undertake care on their own. The length of time a new care staff shadowed was based on their previous experience, whether they felt they were ready, and a review of their performance.

Staff received training to ensure they had the knowledge and skills to meet the care needs of people living in the service. Care staff received training that was specific to the needs of people using the service, which included training in moving and handling, medicines, first aid, safeguarding, health and safety, food hygiene, equality and diversity, and infection control. Nursing staff had been supported and provided with information on courses they could attend at a local hospital to keep their clinical skills updated and current. The training completed was given through a mixture of E learning packages or practical sessions. Care staff told us their training was up-to-date and had helped them understand and support people.

Staff told us that the team worked well together and that communication was good. They told us they were involved with any review of the care and support plans. They used shift handovers, and a communications book to share and update themselves of any changes in people's care. Care staff received supervision from the registered manager. They told us they provided individual supervision and appraisal for staff. This was through one-to-one meetings. These processes gave care staff an opportunity to discuss their performance to identify any further training or support they required. There was a supervision and appraisal plan in place which the registered manager and deputy manager were following to ensure staff had regular supervision and appraisal. Additionally there were regular staff meetings to keep staff up-to-date and discuss issues within the service.

People spoke well of the food provided and staff came around the day before to ask them what they would like to eat. One person told us, "The food is good no problems." Another person told us, "I eat everything I am given. There is no reason to refuse anything it is all very nice." One relative told us, "Beautiful food all homemade." Another relative told us, "Beautiful food. (Cook) is lovely. My mother loves her soup." Lunchtime was relaxed and people were considerately supported to move to the dining area, or could choose to eat in their bedroom. One person had their relative join them for their meal. People were encouraged to be independent throughout the meal and staff were available if people wanted support, or extra food or drinks. People ate at their own pace and some stayed at the tables and talked with others, enjoying the company and conversation.

The cook told us there was a four week rotating menu, which was based on people's likes and dislikes. People were asked to select from the choice available on the day. However, one member of staff told us, "If they don't want anything, they just get what they want." They met any new people living in the service to discuss with them their likes and dislikes. Two options were always available, and we found that people could also make additional requests if there was nothing on the menu that they liked. This information was then fed back to the cook. The cook showed us they had information available on the dietary requirements and likes and dislikes of each person. For example, whether a pureed or soft diet was required. This showed us that staff were aware of individual's preferences, needs and nutritional requirements.

People's physical and general health needs were monitored by staff and advice was sought promptly for any

Requires improvement

Is the service effective?

health care concerns. Care plans contained multi-disciplinary notes which recorded when healthcare professionals visited such as GPs, social workers, nurses or dieticians and when referrals had been made. Feedback from the healthcare professionals we spoke with supported this. Care staff told us that they knew the people well and if they found a person was poorly they should report this to the manager. People were supported to maintain good health and received ongoing healthcare support. One relative told us, “They always keep me well informed about what is happening or if he is unwell.”

Good

Is the service caring?

Our findings

People and their visitors told us people were treated with kindness and compassion in their day-to-day care. They told us they were satisfied with the care and support people received. They were happy and they liked the staff. One person told us when asked if the staff were caring, "They are very nice people." One relative told us, "It is a great relief for me that he is being well cared for in the home. He seems happy here and I take him home occasionally." During our inspection we spent time in the communal areas with people and staff. People were seen to be comfortable with staff and frequently engaged in friendly conversation.

People were listened to and enabled to make choices about their care and treatment. Staff ensured they asked people if they were happy to have any care or support provided. For example, we observed the activities staff informing and encouraging people to take part in the activities arranged on that day. Staff provided care in a kind, compassionate and sensitive way. They answered questions, gave explanations and offered reassurance to people who were anxious. Staff responded to people politely, giving people time to respond and asking what they wanted to do and giving choices. We heard staff patiently explaining options to people and taking time to answer their questions. Staff were attentive and listened to people, and there was a close and supportive relationship between them.

People were consulted with and encouraged to make decisions about their care. They also told us they felt listened to. Care provided was personal and met people's individual needs. A key worker system enabled people to have a named member of the care staff to take a lead and special interest in the care and support of the person. One member of staff told us as part of the keyworker role they ensured the person's room was tidy and they liaised with the person's relative as to what they needed. People were addressed according to their preference and this was mostly their first name. Staff spoke about the people they supported fondly and with interest. People's personal histories were recorded in their care files to help staff gain an understanding of the personal life histories of people and how it affected them today. Care staff demonstrated they were knowledgeable about people's likes, dislikes and the type of activities they enjoyed. Staff spoke positively about the standard of care provided and the approach of the staff working in the service.

People told us care staff ensured their privacy and dignity was considered when personal care was provided. One person told us, "They leave me alone when I want to be left alone." Care staff had received training on privacy and dignity and had a good understanding of dignity and how this was embedded within their daily interactions with people. At a recent staff meeting a dignity survey had been given out to staff and was in the process of being completed. One member of staff had been designated a 'dignity champion' and their role was being developed in the service. 'They were aware of the importance of maintaining people's privacy and dignity, and were able to give us examples of how they protected people's dignity and treated them with respect. One care staff told us that when they assisted people with their personal care they ensured that the bedroom door was closed first before starting the care. We observed staff knocking on people's doors and waiting before entering. For one person who was about to receive personal care a sign was put on their door when personal care was being provided to alert people and ensure the persons privacy. Staff spoke respectfully to the person and explained their actions and ensured the person had given their consent before offering support.

The atmosphere in the service was calm and relaxed, but there was also a general hum of activity. People had their own bedroom and ensuite facility for comfort and privacy. They had been able to bring in items from home to make their stay more comfortable such as small pieces of furniture, pictures and ornaments. People had been supported to keep in contact with their family and friends. Visitors told us there was flexible visiting. People had not required support when making decisions about their care from an advocacy service. However, the registered manager was able to confirm they knew how to support people and had information on how to access an advocacy service should people require this service.

Care records were stored securely. Information was kept confidentially and there were policies and procedures to protect people's personal information. There was a confidentiality policy which was accessible to all staff.

Good

Is the service responsive?

Our findings

People were asked for their views about the service. They said they felt included and listened to, heard and respected, and also confirmed they or their family were involved in the review of their care and support.

Before someone moved into the service, a pre-admission assessment took place. This identified the care and support people required to ensure their safety so staff could ensure that people's care needs could be met. The registered manager told us everyone was visited prior to any admission. If they felt they did not have enough information to make a decision they had requested further information.

The registered manager told us that care and support was personalised and confirmed that, where possible, people were directly involved in their care planning. The care and support plans were detailed and contained clear instructions about the needs of the individual. They included information about the needs of each person for example, their communication, nutrition, and mobility. Individual risk assessments including falls, nutrition, pressure area care and manual handling had been completed. There were instructions for care staff on how to provide support that was tailored and specific to the needs of each person. A nominated registered nurse had been allocated for each person to ensure care plans were reviewed and updated. These had been reviewed and audits were being completed to monitor the quality of the completed care and support plans. One member of staff told us the care plans gave them the information they needed to support people. Where appropriate, specialist advice and support had been sought and this advice was included in care plans. For example, records confirmed that advice and support had been sought from the speech and language team (SALT). During our discussions with staff we found that they knew people and their individual needs and it was evident that they knew them well.

People and their representatives were able to comment on the care provided through regular reviews of people's care and support plans, in residents and relatives meetings and by completing quality assurance questionnaires. Minutes of the residents meetings held confirmed people had been asked for feedback on the meals provided and for suggestions for dishes to go on the menu. They had been kept informed of the changes in the service and the outcome of the survey which had been completed.

People told us there were regular activities provided which they could join in if they wished to. An activities co-ordinator arranged activities in the service five days a week. Or external groups or entertainers were booked to come in and entertain people. The notice boards had information about activities people could attend and people were being reminded and encouraged to join in the activities on offer on the day. One relative told us about the activities co-ordinator,"(name) is fantastic. She does lots of activities. She gets around and talks to people." They told us their relative joined in the activities and staff encouraged her to join in. Another relative told us their relative "Loves her painting, plays bingo and dominoes. She knits."

People were encouraged to raise any concerns. The 'Service user guide' given to people detailed, 'We welcome your comments and suggestions regarding any aspects of care at Oaklands.' People told us they felt it was an environment they could raise any concerns. One person told us, "I have never had anything to complain about and don't think I will have." Relatives told us they had no concerns about the care provided and felt they would be listened to if they had any concerns. People were made aware of the complaints, suggestions and feedback system which detailed how staff would deal with any complaints and the timescales for a response. It also gave details of external agencies that people could complain to. This information was contained within the service user's guide which had been given to people with information about the service. No one we spoke with had raised any concerns and no concerns had been raised since the service had been registered. Care staff were aware that if people or their visitors had any concerns these should be discussed with the registered manager. In addition to the compliments and complaints procedure, the registered manager told us they operated an 'open door' policy and people, their relatives and any other visitors were able to raise any issues or concerns.

Requires improvement

Is the service well-led?

Our findings

People told us they felt the service was well led. One person told us when asked if the service was well led, "Yes, I would like to thank the manager as I am well looked after here." One relative told us there had been improvements to the care provided, the service was cleaner, well run and there were a nice group of care staff. "They all work as a team." However, we found areas of practice which were in need of improvement.

Systems were not fully in place to drive improvement and ensure the quality of the care provided. Quality assurance policies and procedures had not been fully developed. Senior staff carried out a range of internal audits, including care planning; health and safety, and medicines administration. However, they had not been regularly carried out and embedded into the practice of the service. Where audits had been carried out actions were completed, however, actions proposed to address issues highlighted had not all been addressed. For one person who had come in on respite care and stayed in the service systems in place had not highlighted their care plan had not been updated and did not fully detail their care needs. This was an area in need of improvement.

The registered manager understood their responsibilities in relation to their registration with the Care Quality Commission (CQC). Senior staff were aware they had to submit notifications to us, in a timely manner, about any events or incidents they were required by law to tell us about. However, we did find a record of one incident in the service which had not been reported to the CQC as required. Policies and procedures were not all in place for staff to follow. These were in the process of being developed. This is an area that needs to be improved.

There was a policy and procedure on People's responsibility under the Duty of Candour. This is where providers are required to ensure the there is an open and honest culture within the service, with people and other 'relevant persons' (people acting lawfully on behalf of people) when things go wrong with care and treatment. We discussed this with the registered manager during the inspection who demonstrated an understanding of their responsibilities. This had also been shared with staff to ensure they were aware of their responsibilities.

There was a clear management structure with identified leadership roles. The registered manager was supported by a deputy manager. There was a team of registered nurses and senior care staff. The senior staff promoted an open and inclusive culture by ensuring people, their representations, and staff were able to comment on the standard of care provided and influence the care provided. Staff members told us they felt the service was well led and that they were well supported at work. They told us the managers were approachable, knew the service well and would act on any issues raised with them. One member of staff told us, "(manager's name) is good. The nurses are good. It's like my second family." Staff supervision and staff meetings and had been provided the opportunity to both discuss problems arising within the service, as well as to reflect on any incident that had occurred.