Oasis Private Care Limited

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Inspection report

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16 January 2018
17 January 2018
18 January 2018
19 January 2018
22 January 2018
26 January 2018

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection took place on the 16, 17, 18, 19, 22 and 26 January 2018.

Oasis private Care Domiciliary Care Agency (DCA) provides personal care services to people in their own homes. At the time of our inspection 24 people were receiving a personal care service.

At our inspections in September 2015 we found the service was not well led and we rated the service as inadequate in well led. At our inspections in September 2016 we found that the service was inadequate in safe and well led. As a result we placed the service in special measures. Services in special measures are kept under review. We inspected Oasis private care again in February 2017. We found that the provider had made changes. However, due to concerns surrounding the sustainability of the improvements we rated the service as 'requires improvement'. We found at this inspection the changes made had not been sustained by the registered manager.

People were not always protected from abuse and improper treatment. We asked people if they felt safe receiving care from Oasis private care. Although most people said they felt safe, comments made by people and their relatives indicated they were not always protected from abuse or improper treatment.

Systems designed to safeguard people were ineffective. There was an absence of effective systems to enable the provider to have an oversight of the quality of the service.

People were not always protected against the risks of associated with epilepsy. The registered manager and provider did not have an effective risk management process in place to manage medicines safely. The provider had recruitment procedures in place. However, these procedures were not always followed.

The service did not always support people in line with the principles of the Mental Capacity Act (2005). People had not always consented to care.

The system designed at recording and handling complaints was not effective. People were not always involved in developing and reviewing their own care plans.

People and their relatives gave a varied response when talking about the caring nature of staff. Relatives told us people were not always treated with dignity and respect.

The overall rating for this service is 'Inadequate' and the service is in special measures.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made

significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures."

We identified five breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and one breach of the Health and Social Care Act 2008 (Registration) Regulations (2014). We are taking further action in relation to this provider and full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations have been concluded. In the interim we have asked for and received a plan from the provider telling us how they are going to address these concerns to inform our ongoing monitoring of this service.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe. People were not always protected from abuse and improper treatment.

Systems designed to safeguard service users were ineffective.

Medicines were not always managed safely.

Safe recruitment procedures were not always followed.

Is the service effective?

Requires Improvement

The service was not always effective.

People were not always supported by staff who understood the principles of the Mental Capacity Act 2005 (MCA).

Staff told us and records confirmed they were supported effectively

Is the service caring?

Requires Improvement

The service was not always caring.

People and their relatives gave a varied response when talking about the caring nature of staff.

Relatives told us people were not always treated with dignity and respect.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People were not always involved in developing and reviewing their own care plans.

The service was responsive to people's changing needs.

Is the service well-led?

Inadequate

The service was not well led

There was an absence of effective systems to enable the provider to have an oversight of the quality of the service.

The consistency of the quality of the governance systems operated by this provider has been a concern since 2015.

The registered manager of the service had not always informed the CQC of reportable events within a reasonable timeframe.

Oasis Private Care Limited

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 was 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 the 16, 17, 18, 19, 22 and 26 January 2018 and was an announced inspection. We told the registered manager two days before our visit that we would be coming. We did this because the manager is sometimes out of the office supporting staff or visiting people who use the service. We needed to be sure that someone would be in. This inspection was conducted by three inspectors and two experts by experience (ExE). An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

We did not request a provider information return because the inspection was brought forward as a result of concerns we had about the service being provided. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

We reviewed notifications that the registered manager had submitted to us. A notification is information about important events which the provider is required to tell us about in law. Prior to the inspection we spoke with commissioners of the home to get their views on how the service is run.

We spoke with 11 people, 13 relatives, six care staff, one senior care worker, the deputy manager, the quality assurance manager and the registered manager. We looked at 11 people's care records, five staff files and medicine administration records. We also looked at a range of records relating to the management of the service. We visited the homes of six people who receive personal care from Oasis Private Care.

Inadequate

Is the service safe?

Our findings

People were not always protected from abuse and improper treatment. Systems designed to safeguard service users were ineffective. The provider had a policy in place to ensure accidents and incidents were recorded and acted upon. The policy stated 'In the event of an incident, (e.g. a "near miss" which did not result in an injury but which may have done so in different circumstances) an accident/ incident form should be completed and immediately submitted to the registered manager'. However, this system was not always followed. For example, one person had a percutaneous endoscopic gastrostomy (PEG) inserted. A PEG is a tube, which is inserted in a person's stomach in which liquid food and medicines are given. This person had complex care needs and was at high risk of choking. This person had capacity to make decisions about their care needs. Staff told us about incidents were this person had chosen to eat food which subsequently led to them choking. Staff described one of these incidents as, "His head goes red and he is struggling and coughing, he will shout water, water. But we have to wait for [relative] because we can't give food and fluids". There were no records of these choking incidents recorded for this person. When we discussed this with the registered manager they told us this was because it was such a common occurrence they did not complete accident and incident forms. They said, "We would be filling them out all day". The service had not been raised any concerns or risks relating to this person choking with the local authority as a safeguarding concern. We discussed this with the local authority and a professional from the safeguarding team informed us "We have a consultation service and we would expect a provider to use it. Especially with a concern of this nature. This is exactly why we have it".

This is a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) regulations 2014.

One person who was epileptic did not have an epilepsy care plan in place. This is contrary to national guidance which states that service providers [need to] ensure that systems are in place for adults with epilepsy to have an agreed and comprehensive written epilepsy care plan. This person was prescribed emergency medication to support them in the event of a medical emergency relating to their epilepsy. National guidance of epilepsy states that specialist training is needed to give emergency medication. It is also important that people who are prescribed emergency medication have a written plan (or protocol) about when they are given the medication. This person did not have a written plan in place. We were told by two staff members who were responsible for delivering care to this person that they had received specialist training to give the person emergency medication. One of the staff member said, "We had our training on the same day, yes we covered that [emergency medication]". Another staff member said, "We have to administer the medication and if nothing happens then we call an ambulance". We requested evidence from the registered manager that the staff members had received the appropriate training. The registered manager informed us that the staff members had not received specialist training. The registered manager and provider did not have an effective risk management process in place to ensure the risks associated with this persons care needs were reduced. Although the person had not had a seizure for some time there was no information in this person's risk assessment and care plan to guide staff in the event of a seizure.

One person was prescribed morphine to be given when necessary for increased pain. There were nine gaps

on this person's MAR and no explanation why the medicine was not taken. The impact of this was medicines which were not in monitored dosage systems were not always managed safely. Therefore, the provider would not be able to assure themselves that the person had or had not received their medicines appropriately which could lead to either under or over dosing.

We asked the deputy manager what system they had in place to ensure people were receiving their medication as prescribed. The deputy manager confirmed there was no procedure in place to ensure people received their medication as prescribed. Therefore, we could not be assured that medicines were being managed safely.

People were not always protected from the risk of scalding. Three people who had restricted mobility required staff to test water temperatures before supporting them with washing and or showering. One of these people's care records included a document for recording water temperatures. We noted that the correct temperature had been recorded consistently within the document. However, during our observations we witnessed a staff member preparing a bowl of water for this person. The staff member then gave it to another staff member who used this to carryout personal care. It was at this point the male staff member disclosed that the temperature of the water had not been tested in line with their care needs. This put the person at risk of scalding. We asked the staff member who prepared the water if they had tested the water temperature and they told us, "No I haven't". This person's relative showed us a water thermometer and told us, "This arrived yesterday". A second person told us, "They just tell me, it will cool down by the time it gets to you. Today is the first time anyone has checked the temperature". The person told us, "I have been wondering why this turned up yesterday". (Person showed the inspector a thermometer).

This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) regulations 2014.

Medicine administration records (MAR) were not always completed to show when medication had been given. Where codes were used there was no explanation of what the codes meant. For example, code O (Other) was used. MAR charts clearly stated 'O=Other (Please provide details used on reverse)'. None were provided. One person was prescribed an antibiotic and a code O was used on three different occasions without an explanation of what the code meant. The same person was prescribed a cream to be topically administered. Topical administration means application to body surfaces such as the skin. The prescription clearly stated, 'to be given twice a day at 08:00hrs and 1900hrs'. We saw staff signed for the cream three times a day.

People did not always receive a service that met their needs because records relating to the running of the service were not always accurate and up to date. Prior to visiting people who used the service we asked the registered manager to provide 'staffing rota(s) for the week commencing 15th January 2018'. The registered manager provided a rota. However, during our visit to the service it was identified that the rota's provided were not accurate. For example, the rotas included a person who was in hospital and a person who was deceased. Another person's timings were incorrect. We asked the registered manager how staff would know which care visit to attend at which time. They told us, "The staff just know". The deputy manager said, "They are regular so they know when someone is in hospital and their timings".

However people and their relatives told us they often experienced visit times which were not in line with their care or support needs. One person told us, "They do turn up but they are frequently late". Another person said, "We just never know what time they are coming out". A third person stated, "Their timekeeping leaves a lot to be desired. They often blame the traffic but they don't think around the problem, they criss-cross the city rather than planning the visits more logically". A relative said, "The carers had turned up two

hours early for the final evening call". A second relative said, "Sometimes it is okay but I've got tired of it all now, there are often problems now [turning up late]. In the past they haven't even turned up but that hasn't happened for a while now". A third relative said, "The visit was due at noon and they didn't turn up until 2:45pm" and "They're supposed to arrive at 7.00a.m, it could be 7.45am or it could be 8.00a.m. She [person] has to have a strict routine otherwise she panics. They don't stick to it".

The service had an electronic telephone monitoring system to manage care visits. The system logged staff in and out of people's homes and alerted the service if staff were late. We looked at records within the monitoring system and were we identified instances were incomplete calls or late visits had taken place, the deputy manager was able to explain why these instances had happened. However, people we spoke with told us on occasions staff did not remain for the full length of the visit. Comments included; "The carers are supposed to log in and out by phone when they are at the house but sometimes they do not log out and sometimes they come back up to an hour later to log out then", "This is the longest they have ever stayed" and "They don't usually stay this long".

This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) regulations 2014.

People were not always protected from the risk of harm because the provider did not have an effective system in place to ensure new staff were of good character and eligible to work with the people they supported. Prior to our inspection we received feedback from the local authority about a staff member's eligibility to work in the U.K. The provider had agreed with the local authority that they would follow this up and respond to their concerns. However, we found that no action had been taken by the provider to provide an explanation to the local authority. We were informed by the registered manager that the staff member no longer worked for the service. However, the registered manager was unable to provide a date on which the staff member stopped working for the service, therefore the deputy manager contacted the person by telephone and asked them the dates and if they could supply them with the relevant documentation that evidenced their right to work in the U.K. We were informed by the deputy manager that the person was not in a position to send the documents but would send them later that day. We were given assurances by the deputy manager and registered manager that this would be sent following the inspection. However, to date this information has not been received.

The provider had recruitment procedures in place. However, these procedures were not always followed. For example, the policy stated that two satisfactory references must be provided. We looked at recruitment records for six staff members. One member of staff had only one reference on file. Another member of staff did not have any references on file and gaps in their employment history which were not explained. We raised these concerns with the registered manager who was unable to provide a satisfactory explanation.

This is a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) regulations 2014.
Following the inspection the provider has told us they were not fully aware of the requirements in respect of the eligibility of staff to work in the UK but has now sought legal advice to update their knowledge.

People were protected from the risk of infection. Infection control policies and procedures were in place and we observed staff following safe practice. During our observations with staff we noted that clean equipment was used along with personal protective equipment (PPE).

Requires Improvement

Is the service effective?

Our findings

The Care Quality Commission (CQC) is required by law to monitor the application of the Mental Capacity Act 2005 (MCA) and to report our findings. The MCA provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

Although the staff records we looked at confirmed that staff had received training in MCA, staff we spoke with did not always have a good understanding of the Act. One staff member told us, "It's about being declared lawfully to do something, something to do with contracts". Another staff member said, "[Person] does not have capacity and a family member has to make decisions, but [person's] decisions have to be made by [them]. We asked this staff member if they understood the principles of the act and how this related to supporting this person. They told us "No".

There was not always evidence in people care records that they had consented to their individual care needs. For example, two peoples consent forms stated 'I, the signatory below have been involved in drawing up this plan. I give consent for the care plan to be provided as described in the care plan and support plan'. However, these documents had been signed by the registered manager. Another person's consent form was blank, a note had been attached to the document stating 'family giving exercise to sign the care plan will sign on Thursday 18th'. However, this person had the capacity to consent to their own care. A further two people and three relatives informed us that they had not been asked or given consent surrounding people's individual care needs and that files had been updated with notes requesting signatures to consent in the week following our announcement to the provider that we would be inspecting Oasis Private Care. People told us; "Oasis have given us a new file to sign but we refuse to do it", "We did not sign it on purpose, we weren't happy with it", "We have had lots of problems and we know CQC have been on their backs, They took away the Care Plan and returned it with different things in it and asked us to sign it. We won't sign it until we are happy. They keep ringing up asking us to sign it".

Staff training included, induction, safeguarding adults, basic life support, equality and diversity, health a safety, manual handling, fire prevention and dementia awareness. People and relatives if they felt staff were knowledgeable about their individual needs and supported them in line with their support plans. We received a varied response. People told us; "Yes, they have excellent knowledge. They live with me so they get to know me", "They're friends and they know me well, they're lovely people", "Some of the carers are very good but some are not very good at all", "Some carers are better and more capable" and "It is all a bit up and down and I get a bit tired of the moaning and groaning I have to do".

During our observations we witnessed staff communicating well together to ensure care tasks were delivered in line with people's care needs. However, some people and their relatives told us how language could sometimes be a barrier when people were being supported by staff whose first language was not English. One person said, "There can be language difficulties. I was trying to explain how my stair lift worked

to one lady carer but she couldn't understand and in the end I gave up". Another person said, "One new one came and didn't even tell me her name on the first visit and then when I asked her some questions and she did not understand what I was saying". A relative told us, "Sometimes she can't understand what they [carers] are saying".

Records stated newly appointed care staff went through an induction period. Staff told us and records confirmed they were supported effectively through regular supervision, which is a one to one meetings with their manager and yearly appraisals. Staff told us they felt supported by the registered manager and the provider. One staff member told us, "They treat us with dignity and respect and they give us training". Another staff member said, "They are a good company". Staff completed competence checks for specific tasks, for example, percutaneous endoscopic gastrostomy (PEG) feed, oxygen therapy and warfarin administration.

Most people did not need support with eating and drinking. However, some people needed support with preparing meals and these needs were met. One person who did need support told us "I have enough fluids of many descriptions". During our inspection a relative told us, "They're very attentive, they make sure he drinks".

People's care records contained detailed information about their health and social care needs. They reflected how each person wished to receive their care and gave guidance to staff on how best to support people. For example, one person had difficulties communication and required staff to speak at a slow pace. During our observations we observed staff following this guidance. Another person's care records gave specific guidance on how best to support a person's posture whilst they were lying in bed. During our observations we observed staff following this guidance.

Requires Improvement

Is the service caring?

Our findings

People and their relatives gave a varied response when talking about the caring nature of staff. One person told us "I don't need a lot of looking after, they're all excellent. The quality of care is great". Another person said "Some of the carers are very good but some are not very good at all". A third person said "They're always attentive and very kind, we don't have any issues". A fourth person t old us "I want my old carers back". A relative told us "They have no consideration of [person's property] around them". A second relative said "My heart sinks if it is one of the 'wrong ones". A third relative stated "He is not happy with his carers, when he talks to some of them they often ignore him and don't understand him and what he is saying".

Although most people were treated with dignity and respect, people's experiences were different dependent on which staff supported them. One person told us, 'Yes, absolutely, dignity and respect'. Another person said, 'Of course, I am, [treated with dignity and respect] I'd let them know if I wasn't'. A third person said, "The care is quite personal to me but I am not embarrassed and I feel comfortable with them". However, a relative told us "No compassion is shown, some are rude, although some of them are lovely". Another relative said, "Our experience hasn't been very pleasant at all".

We observed staff promoting dignity and respect by ensuring that personal care was delivered in private places of people's homes with curtains and doors closed. We saw staff spoke with people with respect using the person's preferred name. When staff spoke about people to us or amongst themselves they demonstrated compassion and respect. During our inspection we noted that staff were always respectful in the way they addressed people. We observed staff knocking on people's doors

Staff showed concern for people's wellbeing in a caring and meaningful way. For example, one person who required support with eating their meals had swallowing difficulties. During our observations we saw staff supporting this person to eat at a pace that suited their needs. The person told us "[Staff] are very friendly and very nice".

Care records highlighted what people could do for themselves in order to remain independent. This included aspects of personal care, mobility and getting dressed. Were the need to promote independence had been highlighted, there was guidance for staff on how to prompt and support people effectively. We observed staff following this guidance. One person told us, "No one ever tries stopping you doing anything you can already do".

Staff told us how they supported people to do as much as they could for themselves and recognised the importance of promoting peoples independence. One staff member we spoke with highlighted how promoting independence would prevent a rapid decline in people's health and wellbeing. They told us, "It's important we get people to do what they can for themselves".

A relative we spoke with described how staff had supported their family member to attend a family wedding. They told us, 'Two of them accompanied dad to my daughter's wedding last year, he couldn't have gone otherwise'.

Staff understood and respected confidentiality. Records were kept in locked cabinets and were only accessible to staff.

Requires Improvement

Is the service responsive?

Our findings

People told us that they were not informed of changes to their scheduled care visits. One person told us, "One new one came and didn't even tell me her name on the first visit and then when I asked her some questions, she did not understand what I was saying". Another person said, "It seems that we don't get the same ones twice". A relative told us "They do know her I think but one upsetting thing is if they send someone new, she gets so anxious with a new face. It's not fair to send someone who doesn't know her. It's difficult to know who she's getting. They don't tell us who, they just turn up. We ask (is staff member trained) and they say 'No, (I am) just someone new. Then we don't see them again. There's too many changes of staff. They don't know her and I have to tell them what to do all over again". By disregarding individual care needs people felt anxious because they were uncertain of who was visiting them in their own homes.

Some people we spoke with told us that staff spent time following personal care to discussing their care needs. One person told us, "Yes I often have a laugh and a joke with some of them". Another person said, "Plenty of times they stay longer than they need to". A third person told us, "Yes I can have some good chats with some of the carers". However, relatives told us; "Most of the carers seem to have the same attitude, they just do what they have to and then get out", "They never ask any extra questions or go 'off role' and it just does not seem right to me", "No proper care really, they just come in and go" and "They don't spend any time talking to her, some of them say nothing or sit on their phones on [Social media] or playing games. I said to [staff member] once, why don't you just leave and she told me I have to stay for 45 minutes".

This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) regulations 2014.
We asked people and their relatives if they had been involved in the developing and reviewing their own care plans. People and their relatives gave a varied response. One person told us, "They ask me certain things whether I like something or not". Another person said, "I've got a care plan, I go through it with the carers when I want to". However, a relative told us, "They took away the Care Plan and returned it with different things in it and asked us to sign it. We won't sign it until we are happy. They keep ringing up asking us to sign it. I asked why it was taken away. [They told me] to make themselves look better". A person we spoke with told us, "I've not heard of it [care plan]". Another person described how they had been asked to sign a care plan but had not been involved in developing it. Another person's care plan stated 'We will review this plan by 31/03/2017. The person told us, "That never happened". A relative told us, "The Care Plan was replaced with new things in it, they're trying to make themselves less responsible for things".

One person's care records contained details of the person's daily routine and why this was important to them. A staff member we spoke with was able to describe this routine to us as it was written within the persons care record.

One person was referred to GP for increased pain. They were prescribed new pain medicine. The person's care plan had been reviewed to reflect the changes. This person's record indicated they were happy with the support and care received.

One person had difficulty communicating. Staff were guided to communicate with the person by through different non-conventional methods such as different types of hand gestures and allowing the person time to communicate with staff. During our observations we observed staff following this guidance.

Inadequate

Is the service well-led?

Our findings

At our inspection in September 2015 we found the service was not well led and we rated the service as inadequate in well led. At our inspections in September 2016 we found that the service was inadequate in safe and well led. As a result we placed the service in special measures. Services in special measures are kept under review. We inspected Oasis private care again in February 2017. We found that the provider had made changes. However, due to concerns surrounding the sustainability of the improvements we rated the service as 'requires improvement'. We found at this inspection the changes made had not been sustained by the registered manager.

There was an absence of effective systems to enable the provider to have an oversight of the quality of the service. The issues relating to the safety and wellbeing of people using the service, found during the inspection had not been identified. For example the concerns relating to; the risks associated with peoples care, medication practices, records relating to peoples acre and visit times, safe recruitment practices and person centred care. The consistency of the quality of the governance systems operated by this provider had been a concern since 2015. Improvements have not been sustained to ensure the provider is consistently able to meet the requirements of the regulations.

This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) regulations 2014.

Services that provide health and social care to people are required to inform the Care Quality Commission, (the CQC), of important events that happen in the service, without delay. The registered manager of the service had not always informed the CQC of reportable events within a reasonable timeframe. For example, one person had developed a grade four pressure ulcer. Pressure ulcers (also known as pressure sores or bedsores) are injuries to the skin and underlying tissue, primarily caused by prolonged pressure on the skin. A grade four pressure ulcer is the most severe type of ulcer. The skin is severely damaged and the surrounding tissue begins to die. The person also developed a urinary tract infection (UTI) and as a result was admitted to hospital on 29 November 2017. We asked the provider if this had been raised with CQC, and they informed us "Yes it has". However, we checked our records and we noted that we were not notified until 11 January 2018.

This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Registration) Regulations (2014).

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. However, during this inspection and our inspections in September 2016 and September 2017 we have found multiple examples of were the registered manager had failed to comply with the Health and Social Care Act 2008 and associated Regulations.

People gave a varied response when describing how the service was run. Comments included; "Yes, all of the carers are wonderful, it's the admin I have a problem with", "The administration of the agency has not always been good", "[Registered manager] is fairly responsive", "Management is sensitive and knows if there is a problem", "We have met the Manager and we know where to go and who to phone if there is a problem", "We have not made a formal written complaint but we are at the end of our tether with Oasis", 'Trying to get through to the boss is not easy. We were trying last Sunday. I eventually got her late Sunday night. We were trying two numbers, there's an out of hours number but no emergency number", "I tend to just call her if I need to, she's very approachable", "Sometimes but not always (they return my call)", "We don't think (Oasis) have the capacity and capability" and "I'm never sure who's in charge".

We saw some evidence that the service sought people's views and opinions on how the service was running. However, one person told us, "They never ask me". Another person said, "I'm never asked, if there's anything to raise I have to raise it with them, they don't reply to emails unless I make a fuss".