Bupa Care Homes (CFHCare) Limited

Oak Lodge Care Home

Inspection report

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Date of inspection visit:
22 November 2016
25 November 2016

Date of publication:
16 January 2017

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**

Summary of findings

Overall summary

Oak Lodge Care Home is a purpose built home set over four floors providing nursing care for up to 71 people including people who live with dementia, mental health conditions and have general nursing needs. At the time of our inspection there were 65 people living at the home.

A registered manager was not in place at the time of the inspection, although the manager had applied to be registered with the CQC and their application was being processed. 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.

Staffing levels were not sufficient to keep people safe and not enough staff were deployed to ensure people's needs were met in an effective and person-centred way. Due to the staffing levels people were not always protected from individual risks to keep them safe.

Most medicines were managed appropriately, although there was a lack of information about when to administer 'as required' medicines and topical creams were not always documented as given as needed. The issues found in relation to PRN medication and administration of topical creams was discussed with the manager who agreed to investigate these issues and take appropriate action.

Staff sought verbal consent before providing care and treatment, however the service did not always follow the principles of the Mental Capacity Act, 2005 (MCA). Not all decisions made in peoples best interests had been preceded by an assessment of their ability to make the decision themselves. Our findings in relation to the MCA were immediately addressed by the manager.

Not all staff were up to date with the provider's mandatory training, however staff demonstrated a good awareness and understanding of most the training they received with the exception of the MCA training.

The management team had not built a supportive relationship with all staff and relatives. Work was needed by the management team to address low staff morale and the high turnover of staff. Care staff told us they felt unsupported and not listened to by the management team. Although staff received support through supervisions, these were sporadic.

Staff had a good understanding of how to identify if people were at risk of abuse and knew what to do in these circumstances. The provider had a safe and effective recruitment process in place to help ensure that staff they recruited were suitable to work with the people they supported.

People were supported to maintain good health and had access to appropriate healthcare services. Family members confirmed that their relatives were seen regularly by doctors and other healthcare professionals such as GPs, dentists and chiropodists. People's records showed that they had regular contact with these services and the outcomes were recorded in detail.

People and their relatives described staff as "kind" and "caring". We observed positive interactions between people and staff. Staff knew people well and spoke about them fondly. They engaged in meaningful conversations and encouraged people to remain as independent as possible.

People's privacy and dignity were protected at all times. They, and their relatives when appropriate, were involved in planning the care and support their received. Care was delivered in a personalised way and people were supported to make choices.

Care plans included clear guidance about how people wished to receive care and support. They were updated regularly and staff were responsive to changes in people's needs. A range of activities was provided.

Quality assurance systems were in place to monitor both the safety of the environment and the quality of the clinical care provided and these were followed. Issues or concerns raised were acted upon in a timely manner.

We identified breaches of regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we have taken at the back of the full version of the report.

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 safe.

Staffing levels were not sufficient to keep people safe.

People were not always protected from individual risks to keep them safe.

People were protected from the risk of abuse; staff knew how to identify, prevent and report abuse.

Appropriate recruitment practices were in place. Staff understood how to keep people safe in an emergency.

Is the service effective?

Requires Improvement

The service was not always effective

Staff did not followed legislation designed to protect people's rights.

Not all staff were up to date with the provider's mandatory training.

People were supported to maintain good health and had access to appropriate healthcare services.

People were offered a choice of suitably nutritious meals and received appropriate support to eat and drink.

Is the service caring?

Good

The service was caring.

People and relatives were positive about the way staff treated them.

Staff developed caring and positive relationships with people and treated them with dignity and respect.

Staff understood the importance of respecting people's choices and their privacy.

People, and their relatives where appropriate, were involved in planning the care and support they received.

Is the service responsive?

Good

The service was responsive.

Staff demonstrated a good awareness of the individual support needs of people living at the home

Care plans were comprehensive and reviewed regularly to help ensure they reflected people's needs.

People knew how to make complaints and they were dealt with promptly in accordance with the provider's policy.

Is the service well-led?

Requires Improvement

Staff did not feel valued and supported by the management team.

The provider's values were clear and understood by staff.

There were systems in place to monitor the quality and safety of the service provided.

Oak Lodge Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection 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 was unannounced and took place on 22 November 2016 when three inspectors were in attendance and 25 November 2016 which was completed by one inspector.

Before the inspection we reviewed the information that we held about the service including previous inspection reports and notifications. A notification is information about important events which the service is required to send us by law.

We spoke with seven people using the service and engaged with a number of others, who communicated with us verbally in a limited way. We spoke with three nursing staff, 12 members of the care staff, a member of the administration team, the chef, the manager, a relief manager, the regional director and two activities co-ordinators. We also spoke with 11 relatives and four health professionals.

We looked at care plans and associated records for 16 people using the service. We also looked at records relating to the management of the service including staff duty records, staff recruitment files, records of compliments and complaints, accidents and incidents, and quality assurance records.

We observed care and support being delivered in communal areas and used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

The inspection was conducted following concerns we received about the staffing levels and care provision at the home. The home was last inspected in October 2015 when no issues were identified.

Requires Improvement

Is the service safe?

Our findings

Staffing levels were not sufficient to keep people safe. Not enough staff were deployed to ensure people's needs were met in an effective and timely way. Some people and their relatives told us there were enough staff; however, other people, their relatives and visiting professionals described staffing levels as being "inadequate" to meet the needs of the people living at Oak Lodge.

One person told us, "There is enough staff, but sometimes I have to wait, but I'm not the only person in the world." Another person said, "It sometimes takes the staff a long time to get to me". Four of the relatives we spoke with commented on how busy the staff were and two of these felt that there was not enough staff. These relatives both confirmed that they visited at particular times to ensure that their loved ones had received sufficient personal care and support to eat. One relative said, "The carers are really good, but care staff are stressed as they have been short staffed. Weekends are terrible. The other weekend we only had three [care staff] instead of five. There are people they could get up but staff don't when they're short." Two healthcare professionals who visited the home regularly told us, "The staff are good but we are not confident that if we make recommendations about a person's care they [staff] would be able to implement these. The staff are willing but not always able because there is not enough of them".

Of the 15 care and nursing staff we spoke with all but one told us there was not enough staff. One staff member described the staffing levels as, "dangerous at times". A second staff member said, "I would describe the care as [like] a drive through, we just have to do very task focused care, wash, dress, feed and no time for any extras".

The shortage of staff compromised people's safety. People were left in communal areas for up to one hour without stimulation or staff supervision. Looking at these people's care plans and from information provided by relatives, it was clear that some of these people were at risk of falling. One relative said, "It worries me that [my relative] is left in here [in the communal lounge] as no one is around, my relative is at risk of falling".

On day one of the inspection we heard one person calling out for staff to help them get out of bed. After a few minutes a staff member entered the room and provided them with reassurance. The staff member explained to the person that they would return to help them soon but they were currently busy supporting someone else. The person was happy with the explanation from the staff member. However, when the staff member left, the person then attempted to get out of bed independently, which placed them at high risk of falling. In another unit of the home we heard a person calling out for assistance; no staff member responded for nine minutes. On the second day of the inspection, we had to intervene and assist a person who had become unwell in one of the communal areas, as there was no staff around to support them.

During the first day of the inspection we discussed our concerns in relation to staffing levels with the manager. The manager told us that staffing levels were based on the needs of the people and the service and that they used a dependency tool to support them with this. There was a duty roster system, which detailed the planned cover for the home. We reviewed staff rotas for the last four weeks which showed that

the service was not always staffed to the minimum level determined by the provider and manager. For example, during one week in November the home was short staffed on seven occasions. The manager highlighted that this was due to the absences taken by the staff at short notice where staff cover was unavailable. By the second day of the inspection the staffing levels had been reviewed by the manager and the director of the service and an additional staff member had been deployed to two of the units within the home. The manager and director agreed to review the staffing levels and the ways in which the staff were organised on the other two floors.

The failure to ensure sufficient staff were deployed to meet people's needs at all times was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were not always protected from individual risks to keep them safe. Nursing staff had appropriately assessed the risks associated with each individual; these were recorded along with actions identified to reduce those risks, such as the provision of pressure reliving equipment, falls alert mats and the use of bed rail. However these risk assessments were not always followed. Staff had not always changed people's positions as required for those who were at high risk of developing pressure sores. Repositioning charts for four people indicated that the people needed their positions changing every four hours. On viewing these charts all four had not always been support in accordance with the recommendations. When this was discussed with the care staff and nurses, all were able to confirm who was at high risk of skin breakdown and what actions were needed to prevent this. However, some staff confirmed that people did not always have their positions changed as recommended. One staff member said "We try our utmost to deliver care [when we are short staffed] but sometimes we're late with the turns."

The failure to assess and mitigate risks to the health and safety of people using the service was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

One person had fallen out of bed which caused a minor head injury. Equipment had been put in place to prevent further falls and initial neurological observations were completed. However, following the initial neurological observations, further observations were not continued regularly, as recommended by the National Institute for Health and Care Excellence (NICE). NICE provides national guidance and advice to improve health and social care. We spoke with two nurses and the relief manager who were clear about the need to follow NICE guidance. The manager showed us the forms they used for this purpose and provided an example of where they had been completed for another person. They attributed the failure to complete the observations on this occasion to the agency nurse who was on duty at the time, who may not have been aware of the provider's policy. The manager agreed that they would address this issue with the agency staff who worked in the service.

The deputy manager analysed the incidence of falls and other incidents on a monthly basis to identify any patterns. They described the action they would take if any themes were identified. For example, they had identified a series of skin tears to people and had reviewed moving and handling practices and reminded staff of the importance of wearing appropriate clothing.

People received oral medicine safety, as prescribed and on time. One person told us "I always get my medicine when I need it". Medicines administration records (MAR) in relation to oral medicine were completed correctly. The MAR chart provides a record of which medicines are prescribed to a person and when they were given. Staff administering medicine were required to initial the MAR chart to confirm the person had received their medicine, which they had done.

However, prescribed topical cream records were not accurately recorded or up to date. We viewed the

topical MAR charts of five people in two units of the home and found that topical creams had not been recorded as administered. A nurse and members of the care staff told us that topical creams were used as prescribed. These staff members told us that the MAR charts were not accurate and should have been completed.

Guidance had been developed to help staff know when to administer 'as required' (PRN) medicines, such as pain relief and medicines to help reduce people's anxiety. Where people were not able to state they were in pain, a pain assessment tool was used. We saw that PRN medication had been given to people but the reasons why this had been administered had not been recorded. This meant that trends could not be easily identified. For example, if a person had been given frequent pain relief for a recurring issue this may need to be investigated further. The issues found in relation to PRN medication and administration of topical creams were discussed with the manager who agreed to investigate these issues and take appropriate action.

Suitable arrangements were in place for obtaining, storing, administering and disposing of medicines. Staff administering medicines had received appropriate training and had their competency assessed. Nurses were observed administering medicines competently; they explained what the medicines were for, did not hurry people and remained with them to ensure that the medicine had been taken.

Some of the people in the home required medicines to be given covertly. This is when essential medicines are placed in small amounts of food or drink and given to people. There was a procedure in place for the covert administration of medicines and staff were able to describe how and when medicines should be given this way. Staff respected people's rights to refuse prescribed medicines. One of the nurses described the action they would take if medicines were declined.

Staff had a good understanding of how to identify if people were at risk of abuse and knew what to do in these circumstances. A staff member told us they had flagged up a concern about the way a family member was supporting their relative to move. They said, "I flagged it up to the nurse and a social worker got involved." Another staff member told us they had been concerned about the way a carer behaved towards a person and reported this to the manager who acted immediately. Staff were aware of external organisations they could contact for support, including CQC and the local safeguarding authority. A staff member said, "We care and worry about the residents and want to protect them."

The provider had a safe and effective recruitment process in place to help ensure that staff they recruited were suitable to work with the people they supported. All of the appropriate checks, such as references and Disclosure and Barring Service (DBS) checks were completed for all of the staff. A DBS check will identify if prospective staff had a criminal record or were barred from working with children or vulnerable people.

People experienced care in an environment which was clean and appropriately maintained. Care staff had received infection control training. While observing care we saw staff using their personal protective equipment, such as disposable gloves and aprons when supporting people, in line with the Department of Health guidance. The manager had completed an infection control risk assessment and infection control audits to ensure people were safe.

Risks posed by the environment had been assessed and were being managed appropriately. Equipment, such as hoists and lifts, was serviced and checked regularly. Upstairs windows had restrictors in place to prevent falls and fire exit doors were alarmed so staff would be aware if anyone had left the building without their support. The temperature of hot water at water outlets was controlled through special valves and maintenance staff monitored these regularly. This helped protect people from the risk of scalding.

There were plans in place to deal with foreseeable emergencies. Staff were clear of the action to take in the event of a fire. Fire safety equipment was maintained and tested regularly. Nurses had been trained to administer first aid.

Requires Improvement

Is the service effective?

Our findings

People and their families told us that they were cared for by staff who were skilled to carry out their roles effectively. One person said of the staff, "They are very good, they know what I need". A relative said, "All the staff are hard workers. I think they do an excellent job. They are well trained, even the new ones." Another relative told us, "[Staff are] well trained and know what they are doing."

We observed that people looked cared for, in that they were wearing clean clothing that was appropriate for the weather and that their individual personal grooming needs were met, such as hair care and nail care.

Staff had mixed views on the training they received. Staffs comments included, "I had lots of training when I first started, but I know I'm not up to date with my mandatory training", "I don't have time to keep up to date with the training, due to the home being short staffed" and "We get lots of training opportunities". A nurse told us they had recently completed the 'seven steps' end of life care programme through a local hospice. They said all their training was up to date and they were supported to meet the Continued Professional Development (CPD) requirements of their registration.

Not all staff were up to date with the provider's mandatory training. The provider had a system in place to record the training that staff had completed and to identify when training needed to be repeated. This included essential training, such as medicines training, safeguarding adults, fire safety and first aid. Staff had access to other training focused on the specific needs of people using the service, such as; dementia awareness, managing behaviour we find challenging, skin integrity and use of syringe drivers. On reviewing the provider's training log we found staff did not always complete the provider's mandatory training in a timely manner. This was discussed with the manager who acknowledged that this could sometimes be an issue. It was agreed the manager would address this.

Staff demonstrated a good awareness and understanding of most the training they received. Staff were able to tell us how they would appropriately care for people living with dementia, how they would support people when they put themselves or others at risk and how they would effectively communication with people. For example, one staff member said, "[One person] struggles to make choices, so I support them by limiting the options to two items of clothing or two meals." The staff member's understanding of the training received was confirmed during our observations of care provision.

We found that people were supported by staff who had received an effective induction into their role, which enabled them to meet the needs of the people they were supporting. Each member of staff had undertaken an induction programme, including a period of shadowing a more experienced member of staff who assessed their suitability to work on their own. Staff were also required to complete a workbook, that met the principles of the care certificate, which needed to be signed off by a senior member of staff. The Care Certificate is a set of standards that health and social care workers adhere to in their daily working life.

Although staff received support through supervisions, these were sporadic. Supervisions provide an opportunity for management to meet with staff, feedback on their performance, identify any concerns, offer

support and identify learning opportunities to help them develop. One staff member said, "I can't remember my last supervision. It may be three years ago. They can't spare us off the floor." Another staff member told us, "I get supervision about three monthly I think", and a third staff member said, "I think I get supervision every six months, but can approach the manager at any time if I have any concerns". The manager told us they had identified that supervision had been sporadic during an audit of the service. They showed us a copy of plans they had recently put in place to ensure staff received supervisions and annual appraisals in line with the provider's policy.

Staff did not always protect people's rights by following the Mental Capacity Act 2005 (MCA). 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 decisions made on their behalf must be in their best interests and as least restrictive as possible. From speaking with the staff in the home on the first day of the inspection, it was clear they did not understand how to apply the Mental Capacity Act, 2005 (MCA) to the care planning process. Staff comments included "I don't really understand it" and "I haven't had any training on this".

One care plan contained an assessment of the person's ability to consent to 'the care planning process'. This concluded that the person lacked the capacity to do this, but staff had not followed this up with any best interests decisions. Additionally, consent forms in this person's care file had been signed by a family member who had not been given the legal authority to make these decision on the persons behalf. The record indicated that the family member had given themselves permission to consent to the care, treatment and interventions their relative should receive. Other care plans we viewed contained a generic 'best interests decision' form which highlighted that a number of interventions were required in the person's best interests. These were not decision specific, did not explain why the interventions were required and who had been involved in making the decisions.

Not all decisions made in a person's best interest had been preceded by an assessment of the person's ability to make the decision themselves. Another person was receiving most of their medicines covertly. An assessment form had been completed, showing that the person's family and their GP had been consulted and a best interest's decision made to administer medicines in this way. However, staff were unable to provide any records to show that the person's capacity to make decisions about their medicines had been assessed prior to them making a decision on behalf of the person.

Staff sought verbal consent from people before providing care and support. Care plans contained information about how staff should support people to make as many choices and decisions as possible. For example, one person's care plan stated: "Support needed with decisions. Make eye contact, use visual prompts, exercise patience, use simple conversations to gain 'yes' or 'no' answers." We saw staff using these techniques and gaining people's agreement before supporting them to change position and supporting them to eat.

During the first day of the inspection we discussed our findings in relation to the appropriate use of the MCA and best interest decisions. When we returned to the service for the second day of the inspection a number of the staff had received additional training in this area, best interest forms had been updated and further training had been arranged.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles

of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. We found the provider was following the necessary requirements. DoLS applications had been made to the supervisory body with the relevant authority for all of the people using the service that were deemed as not having capacity.

People were supported to have enough to eat and drink and we saw drinks and snacks being offered throughout the day. One relative said, "[My relative] is looked after really well. She eats well and enjoys the meals", and a second told us "A lot of people don't eat well, but [staff] do try to encourage them."

Meals were prepared by the chef and served by staff who demonstrated an awareness of people's likes and dislikes, allergies and preferences. Staff spoke with people before each meal to explain what options were available. People were provided with alternative food choices, such as an omelette or a sandwich if they didn't want what was on the menu or if they had not eaten well. During lunchtime we saw one person had eaten very little of the meal they had chosen and the staff member offered them assistance or an alternative food choice. Care staff were seen fully supporting those that could not eat independently and this was done in a patient, respectful and unhurried way. Some people who were being nursed in bed needed support to drink and we saw staff provided this on a regular basis throughout the day.

People's food and fluid intake was monitored where people's nutritional intake was poor and this was supported by the use of individual food intake diaries. Staff told us that when a person had an infection, reduced appetite or unplanned weight loss a food and fluid chart would be put in place to monitor their intake. We looked at a number of food and fluid charts and most appeared to be up to date and detailed. Two charts showed gaps in the recording of food and fluid intake. A nurse explained that one of these charts was for a person who had become quite unwell over the last 12 hours, the GP had been contacted and mouth care had been commenced. However, the nurse was unable to explain why recording had stopped on another person's chart.

Where people were fed through a percutaneous endoscopic gastrostomy (PEG), (a tube surgically passed into their stomach through the abdominal wall) there was a clear plan in place. A nurse was able to explain the feeding regime for a person who had a PEG and the risks associated with this. Some people needed their drinks thickened to prevent them from choking. Staff were clear about how to do this and the consistency that each person required. We saw drinks being given at the right consistency and guidance about the need to thicken fluids was being followed.

People were supported to maintain good health and had access to appropriate healthcare services. Family members confirmed that their relatives were seen regularly by doctors and other healthcare professionals such as GPs, dentists and chiropodists. People's records showed that they had regular contact with these services and the outcomes were recorded in detail.

People's records showed that referrals had been made to additional services when required. These referrals included, the speech and language team (SALT) to assess people with swallowing problems, dieticians for advice about a person's reduced food and fluid intake and the older persons mental health team for assistance in supporting the mental health of a person with cognitive impairment. We saw evidence in people's records that advice given had been acted upon. For example, one person's weight had increased over a six week period following advice from the dietician and staff had implement different care approaches, as recommended, when providing care to a person with a challenging cognitive condition.

A nurse told us that they had recently liaised with a person's GP, and obtained medicines to keep them comfortable as they were nearing the end of their life. The nurse said "[The staff] aim is to keep the person

comfortable and involve and support the family as much as possible during their visits".

Good

Is the service caring?

Our findings

Staff treated people with kindness and compassion. One person told us, "The staff are very amicable, I am really well looked after", and another said, "The staff are great, they are nice to me". Relatives comments included, "Most of the staff are brilliant", "All the staff are wonderful" and " [The staff] are a very good bunch."

Staff talked fondly of the people they cared for. One staff member said "I love working here, the residents are great and so is the staff team". Another care staff member told us, "I love my job, I want to provide the people with the care that they need". Three members of the staff team talked about the guilt they felt about not having time to spend with the people. One staff member said, "The staff shortages make you so upset because you want to do your best by people but you can't." A relative said, "They [staff] have problems at times as they are short of staff; but they cope well and always have a smile on their face. [The shortages] don't have an impact on [my relative]. She's never neglected; they always clean her and give her lunch. [Staff] just work harder and probably go home exhausted."

Staff treated people with dignity and their privacy was respected at all times. One relative said, "They protect [my relative's] privacy by closing the curtains and doors when providing care". Staff were able to describe the practical steps they took to preserve people's dignity and privacy when providing personal care. This included ensuring doors and curtains were closed and making sure people were covered. We observed staff knocking on doors, and asking people's permission before entering their bedrooms. Confidential care records were kept securely and only accessed by staff authorised to view them.

Interactions between people and staff were positive and friendly. We heard singing and laughter behind a closed door while a person was receiving personal care. Staff were seen to kneel down to people's eye level to communicate with them and spoke to them kindly, giving reassurance and time to respond. We heard good-natured banter between people and staff showing they knew people well. For example, we heard one staff member offer a person a drink; when the person said "yes" the staff member said "Your usual, tea with two?". A relative said "They [staff] know all about [my relative] and their needs are met". An advocate who visited the home often told us, "I see consistent staff. They stay on each floor so they get to know people."

People were offered choices about how they wished to receive care and their right to decline care was respected. For example, we heard one person be offered a shower or a bath; when these choices were declined the staff member said, "Shall we just give you a bed bath today then and perhaps a bath or shower tomorrow?". A person also told us, "They [staff] came to help me get up this morning but I wanted a lie in; they didn't mind and I'm very happy".

One staff member had spent time creating knitted items for people to interact with in their own time. These included a 'fiddle muff' in the person's favourite colours which had items sewn on to it which were meaningful to them and which they enjoyed interacting with. A novel doll, which could be turned inside out, had been made for another person. A third person was seen interacting with a knitted pyramid. It had been personalised to them and had items of interest attached and inside it, which the person enjoyed exploring.

Tactile items such as these are known to be of value to people with dementia to help stimulate them. A family member told us, "[The care staff member] who makes the items is brilliant. They're all personalised to each of them. For [one person] it has pride of place and they're never without it."

Staff supported people to maintain family relationships. Relatives told us they could visit at any time and were also given the opportunity to attend home events and activities. During both days of the inspection a number of relatives were seen around the home. One told us, "I was offered dinner today and it was lovely".

Good

Is the service responsive?

Our findings

The service was responsive to people's needs and people told us they received personalised care and support that met their needs. Staff demonstrated a good awareness of the individual support needs of people living at the home, including those living with dementia. They knew how each person preferred to receive care and support; which people needed to be encouraged to eat and drink; the support each person needed with their continence; and when people liked to get up and go to bed. Rooms were personalised with photographs, pictures and other possessions of the person's choosing and memory boxes and other age-appropriate memorabilia was available around the home to support people to reminisce.

When people moved to the home, they and when appropriate their families were involved in assessing, planning and agreeing the care and support they received. Family members told us they were involved in discussions about their relative's care and were kept informed of any changes to their health or well-being. One relative told us, "[Staff] talk to me about [my relative's] care; they're very good. I can see the care plan every day if I want to." Another said, "[The person] hasn't been at Oak Lodge long but we [relatives] were asked lots of questions about them when they arrived".

Individual care plans were well organised and the guidance and information in these were detailed. Each person had a care plan in place which contained comprehensive information to enable staff to support people in a personalised way. As well as detailed information about the person's care needs in relation to health, personal care support and dietary needs, they also contained detailed information about the person's, likes and dislikes, family and personal history, past jobs and hobbies and interests. Information highlighted in these included, "[The person] likes to watch television and listen to their music". When we visited this person in their room it was evident that the information in the care plan had been followed. Another care plan stated 'I like a bed sheet and a blanket at night' and third advised staff to 'Use simple and direct questions when communicating with [the person]'. A relative told us "[My relative] likes a bit of make up on in the morning, and [staff] do that for her." We discussed the information we had seen in the care plans with the staff who demonstrated that they knew the people they cared for well and understood the ways they wished to receive care. Evidence within the care plans indicated that they were reviewed by the nursing staff monthly or more frequently if individual needs changed.

Staff were kept up to date on people's needs through a handover meeting when they arrived on shift. This meeting provided the staff with a range of important information about people's conditions and included any special instructions for staff. For example, if anyone needed to be weighed or had additional care needs. These handover meetings were supported by written information updating the staff on people's needs.

People, relatives, staff and professionals who visited the service has mixed views about whether people had access to appropriate mental and physical stimulation. One relative said, "I think there's enough stimulation for people. The calming music is nice; they enjoy that. The activity coordinators are very good and involved [my relative] as much as possible." A second relative told us, "Activities happen in the lounge which [my relative] can't get to; but once a week someone comes round to play the guitar to her. They also brought an owl round to her recently for her to stroke; I think she enjoyed that". However other relatives and some

visiting professional's felt that there was a lack of stimulation for people. One visiting professional who often visited Oak Lodge told us, "There seems to be a lack of stimulation. I don't often see activities going on, although I think the activity coordinators are starting to visit people on a one-to-one basis." A health care professional said, "The care staff are so busy they don't seem to be able to spend any time just talking to people".

On day one of the inspection we saw very little interaction that was not task focused between the people and the care staff. Staff detailed to us the jobs which needed doing throughout the shift and these jobs all related to personal care and physical tasks, not about supporting people emotionally. However, on the second day of the inspection we witnessed activities and physical and mental stimulation being provided by two activities co-ordinators that were employed by the service. These activities included making table decorations for Christmas, arts and crafts, taking one person for a walk in the garden and encouraging people to choose new Christmas decorations for the home.

The provider also arranged external services, such as singers, church services, musicians, dancers, gardening therapy sessions and visits from animals and their handlers. Activities were provided both in groups and individually and were adapted according to the likes and preferences of people on a day to day basis. People who remained in their bedrooms by choice or because of their care needs were given the opportunity to receive one to one activities. People and their families were kept informed of forthcoming events and daily activities though the activities notice board and directly from the staff.

The manager sought feedback from people and their families on both a formal and informal basis and told us she had an open door policy. The manager told us, "I am happy to meet with the people and their relatives whenever they need support or want to raise issues or concerns". The acting manager held three monthly 'relatives meetings' which provided relatives with the opportunity to discuss any issues or concerns they had in relation to the care provision and environment. We viewed minutes of these meeting and saw that a range of topics were discussed, including the standards of the food, cleanliness of the environment and staffing issues.

People told us staff were responsive when they raised concerns. For example, a family member said, "I went to a meeting and raised the issue of dirty chairs and they have now been cleaned." Another family member told us, "I complained about [staff] as [my relative's] bed was wet in the morning. I asked the nurse to make sure they were changed at night and it is better now". The provider had a policy and arrangements in place to deal with complaints. They provided detailed information on the action people could take if they were not satisfied with the service being provided. Leaflets were readily available and posters were displayed at various locations around the home detailing ways in which people and their relatives could complain about the service.

Requires Improvement

Is the service well-led?

Our findings

A registered manager was not in place at the time of the inspection, although the manager had applied to be registered with the CQC and their application was being processed. 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.

Although there was no registered manager there was a clear management structure in place. This structure consisted of a regional director, manager, a deputy manager, heads of departments, nursing staff, senior care staff and care staff. Staff understood the role each person played within this structure. The manager was present on both days of the inspection and was responsive to the concerns raised during the inspection and took immediate action were they were able to.

The management team had not built a supportive relationship with all staff and relatives, which had resulted in low staff morale and a high staff turnover. A number of the care staff told us they felt unsupported and not listened to by the management team. One said, "Staffing is a big issue as so many are leaving. Staff don't want to come in to cover as they're exhausted". Another member of the care team said, "We [care staff] get the blame for the fact that we are so short staffed; we are told by the manager that it is our fault because we won't do extra shifts". A third staff member told us, "The management team don't listen to us; we have told them we need more help on the floor but they will say we have all the staff we need. One of the management team is a nurse yet they will never help with hands-on care when we need it". A further staff member said, "I feel unsupported and undervalued, it upsets me". A relative told us, "The manager doesn't know who people are and hasn't introduced herself to patients, relatives or staff", and another said, "I don't know who the manager is". However, another relative said, "The new manager stipulated that there should always be a carer in the lounge, which is good." Non care staff comments included, "The manager knows what's going on and is supportive", and, "The manager is firm but fair".

The manager told us that the home held regular staff meetings for different areas of the staff team. These included monthly nursing meetings to discuss clinical issues and quarterly care staff meetings. These meetings are held to provide the staff with the opportunity to discuss any concerns or issues they or management had and to keep staff up to date with the running of the service. We saw meeting minutes from a recent night staff meeting which demonstrated a good level of staff attendance. Relatives meetings are held every three months to provide people and their families with the opportunity to talk to the management team about the running of the service and the care that is received. People and their relatives were notified of these meetings verbally and through the homes notice board and minutes from these meetings were sent to relatives.

Quality assurance systems were in place to monitor both the safety of the environment and the quality of the clinical care provided. Routine checks and audits were regularly carried out for a range of areas, including infection control, the cleanliness of the home, resident involvement and care plans to enable the manager to monitor the operation of the service and to identify any issues requiring attention. The audit of care plans confirmed that peoples care needs were reviewed regually, but did not assess whether the

individual reviews had been completed effectively. For example, the audit had not identified that the Mental Capacity Act was not being followed and people were not having their positions changed as advised by healthcare professionals.

There was also a system of audits in place to ensure that safety checks were made in respect of water temperatures, medicine storage temperatures and fire safety. Weekly medicine audits were completed by the nursing staff and the deputy manager completed a full medicine audit monthly which covered all areas of medicines management. However, these medicine audits failed to identify the gaps on the MAR and lack of information in relation to the use of PRN medicine. The provider had developed an audit for 'resident of the day'; this allowed the manager or deputy manager to concentrate on one person's care record and ensure it was reviewed fully. A 'first impression audit' was completed monthly by a different member of staff each month. This was to get different views of the service to see how things appeared at first glance. This would look at the safety and cleanliness of the environment, how people appeared to be cared for and an overview of the culture of the home and care provided. Areas of concern raised in these audits were recorded in the home improvement plan to allow action to be taken.

Other formal quality assurance systems were in place, including seeking the views of people about the service they received. This was done through surveys being sent to people and relatives to get their views on the care and service. Completed questionnaires were sent directly to the provider to review who then compiled a report of the findings and developed an action plan to help ensure improvements were implemented.

The manager carried out an informal inspection of the home during a daily walk round; this was done to look at the safety within the environment and talk to the people and staff. Where issues or concerns were identified these were immediately addressed or an action plan was created and managed through the regular meeting processes. There was a "10 at 10" meeting daily which involved heads of departments, the deputy manager, the acting manager and clinical staff. This meeting was held to keep staff updated on any changes in the care needs of the people and to raise environmental concerns.

Senior representatives of the provider were engaged in running the service and their vision and values were built around 'delivering high quality care, while running a commercially successful business'. The manager told us that their vision and values were, "To make the last chapter of the person's life good and comfortable, look at the whole person, as well as listen and support families". The vision and values of the service and how these related to their work was discussed with the care team, who all demonstrated a clear understanding of them. One staff member said, "We [staff] just want the people to have a good quality of life". Another staff member told us, "We [staff] think the people who live here should feel safe and loved and we do our best to achieve this".

The provider had suitable arrangements in place to support the manager, including regular meetings and visits from the regional director which also formed part of the provider's quality assurance process. The acting manager confirmed that support was available to them from the provider and they were able to raise concerns or discuss issues with the registered managers of other locations operated by the provider.

At the time of the inspection there was a forthcoming visit from a local school to sing Christmas carols and the home had close links with the local church who visited regularly. The manager is planning to develop further links with the community which would benefit people.

Although not yet registered, the manager understood the responsibilities of a registered manager and was aware of the need to notify the Care Quality Commission (CQC) of significant events regarding people using

the service, in line with the requirements of the provider's registration. Visitors were welcomed at any time and the rating from the previous inspection report was displayed in the reception area and on the provider's website.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to mitigate risks to the health and safety of people using the service effectively. Regulation 12(1) & 12(2)(a) & (b).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had failed to ensure that sufficient numbers of suitably qualified, competent and skilled staff were deployed in order to meet their needs. Regulation 18(1).