Oaktree (Clevedon) Limited

Oaktree Lodge Residential Home

Inspection report

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19 February 2018

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

The inspection of Oaktree Lodge Residential Home took place on 15 and 19 February and was unannounced. This was a comprehensive inspection. The previous comprehensive inspection of the home was carried out in July 2016 and the service was rated as requires improvement. Four breaches of regulations 12, 17, 18 and 19 of the Health and Social Care Act 2008 were identified. These were because people were not receiving their medicines safely, care plans did not always guide staff how to support people safely, there were no audits in place to identify shortfalls, recruitment checks were not always carried out and staff did not always have sufficient training. We served a requirement notice for these breaches of regulations. At this inspection we found the provider had made improvements and there were no breaches of regulation.

Oaktree Lodge Residential Home also provides a domiciliary care service to people in their own homes, we therefore gave 48 hours notice to the provider. This was because we wanted to speak with people in their own homes and wanted their permission to do this. However the provider had given notice that they would cease delivering this service on 7 March 2018. During our inspection, we therefore only focused on the leadership, management and forward planning towards closing this part of the service.

During this inspection we checked that the provider was meeting the legal requirements of the regulations they had breached. You can read the report from our last comprehensive inspection, by selecting the 'All reports' link for Oaktree Lodge, on our website at www.cqc.org.uk.

Oaktree Lodge Residential Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Oaktree Lodge residential home provides care and accommodation for up to 34 people older people and people living with dementia. On the days of the inspection 30 people were living at the home. The home was over four floors, with access to all floors either via stairs or the lift.
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.

People and their relatives were complimentary about the registered manager, the staff and the care they received. Staff knew people well and delivered care in the way they preferred. The service had a relaxed homely atmosphere and was clean throughout.

People's care needs any risks to their health and wellbeing were comprehensively assessed and clear plans were in place to guide staff on how best to support people. There were good systems in place to identify any

changes in people's health and well-being and staff took swift action when they identified any health needs.

Staff were competent, knowledgeable and caring and recruited safely. They received appropriate training and supervision. The registered manager monitored staff performance and addressed any issues promptly.

People had plenty to eat and drink and had a choice of food and drink. Staff ensured people received support if needed but promoted independence as much as possible.

Staff respected people's decisions and understood how to support people to make their own choices. Regular activities were available for people should they wish to take part, however, if people wished to spend the majority of time in their room this was respected.

The provider had an effective governance system in place to manage the quality of the service. There was a system of daily checks by senior staff and deputy managers overseen by the registered manager. These checks ensured staff carried out their tasks to the standard expected by the manager.

Medicines were mostly managed safely. We identified a training need in the administration of aerosol inhalers and a missed dose of one medicine which we brought to the attention of the registered manager. We have made a recommendation about this.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

Staff were aware of the processes in place to help make sure people were protected from the risk of abuse and were aware of safeguarding procedures.

Assessments were undertaken of risks to people who used the service and staff. Plans were in place to manage these risks. There were processes for recording accidents and incidents .

People were protected from the risks associated with poor staff recruitment because a full recruitment procedure was followed for new staff.

There were usually enough staff to meet people's needs.

However, there were some minor shortfalls in medicines administration.

Is the service effective?

Good

The service was effective.

Staff received an induction and training in subjects the provider considered mandatory, had regular supervision and were knowledgeable and competent.

People had plenty to eat and drink with appropriate support if needed.

Staff communicated well with other services such as the GP and district nurses.

People's rights were respected, and the service was following the best interest's framework of the Mental Capacity Act (2005). People's choices were supported.

Is the service caring?

Good

The service remained caring.

People were cared for by staff who knew them well and were patient, respectful and kind.

People's preferences and choices were respected.

Staff maintained people's privacy and dignity.

People were supported to be independent where possible.

Is the service responsive?

Good

The service was responsive.

People had received a comprehensive assessment to identify their needs.

People had clear care plans which contained their preferences and care needs.

Complaints had been responded to.

People's wishes for their end of life care was respected.

Is the service well-led?

Good

The service was well-led.

Everyone was complimentary about the registered manager.

There were effective systems in place to monitor the safety, effectiveness and quality of the service.

Staff morale was good and staff felt supported in their role.

The provider was engaged in the running of the service.

Oaktree Lodge Residential Home

Detailed findings

Background to this inspection

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

This inspection took place on 15 February 2018 and was unannounced. We returned on 19 February 2018 to check on how the provider was managing the planned closure of their care at home service.

The inspection team comprised two adult social care inspectors, a specialist professional adviser with experience of older adult nursing, and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give key information about the service, what the service does well and improvements they plan to make. We reviewed the PIR and other information we had about the service including statutory notifications. Notifications are information about specific events that the service is legally required to send us.

Some people at the service were not able to tell us about their experiences. We used a number of different methods such as undertaking observations to help us understand people's experiences of the home. As part of our observations we used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the needs of people who could not speak with us.

During the inspection we spoke with seven people living at the home, two relatives and seven staff members, this included senior staff, two directors of the registered provider and the registered manager. We also spoke with three visiting health professionals. We reviewed six people's care and support records and

six staff files. We also looked at records relating to the management of the service such as incident and accident records, meeting minutes, recruitment and training records, policies, audits and complaints.

Good

Is the service safe?

Our findings

During the comprehensive inspection in July 2016 we found breaches of regulations 12, 17 and 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations (2014), because people were not receiving their medicines safely, care plans did not always guide staff how to support people safely and there were no audits in place to identify shortfalls in the service. At this inspection we found improvements had been made.

People told us they felt safe. One person said, "I feel safe here, I have settled down and can talk to any staff", and a second person told us, "I am safe and comfortable, nothing bothers me, staff pop in to see that I am alright." A relative visiting the service said, "I am confident my relative is safe here, since being here they have not had a fall, a frequent occurrence when they were at home."

People were safeguarded from risks of abuse. Staff were clear about their responsibility to report any concerns. Staff told us they were confident that concerns would be followed up. One staff member told us , "If management weren't dealing with it, I wouldn't let it go. I'd sort it out because I couldn't sleep if things weren't right." In addition to a comprehensive safeguarding policy the provider had an 'unexplained bruising' policy in place which directed staff on actions to take on discovering any bruising. Records showed that any concerns had been reported and the local safeguarding adults' team had been informed where indicated by the policy. There were no on-going safeguardings at the time of the inspection.

Risks to people's safety were properly managed. Staff had carried out a comprehensive assessment of each person's risks. Each person had risk assessments completed for specific needs such as eating and drinking, skin integrity and falls. There were clear plans in place to guide staff on how to manage these risks. Staff confirmed they had sufficient information to keep people safe. One person was at risk of developing pressure ulcers . There was a clear system in place to alert staff when to contact the district nursing team.

The registered manager had introduced a system to identify and support people at risk of falls. People had their falls risk assessed and a plan and actions in place to help reduce the risk. For example, all the people we saw in the home had well-fitting footwear. Staff reported all falls through the incident reporting system. Falls information was transferred to a spreadsheet which the registered manager used to monitor trends, actions taken and outcomes. For example, it was identified one person was not using their walking frame. Another person had developed health problems which were identified by an increase in the number of falls.

People had plans in place to guide staff on how to support them to move around the home safely. We witnessed safe moving and handling techniques, staff gave clear information and reassurance throughout any transfers. One staff member used hand gestures in addition to speech when supporting a person who had a hearing loss. The provider had ensured all related equipment was checked and maintained in line with the manufacturer's guidelines.

People and visitors told us there were enough staff available to meet their needs, apart from one person. This person told us, "There are not always enough staff, especially at night when they are signing off

[handover], people have to wait maybe for 10 minutes." Staff reported they had enough time to carry out tasks, and that there were usually enough staff on duty. The home seldom used agency staff, and absences were covered by regular staff. Between 8.00am and 8.00pm, there was always a deputy manager on duty, with the Registered Manager present during office hours. In addition, a senior staff member was available during the daytime shifts. The provider told us the registered manager was always available to deliver care to people if needed.

The provider had followed appropriate recruitment processes before new staff began their employment. Staff files showed photographic identification, a minimum of two references, full employment history and a Disclosure and Barring Service check (DBS). A DBS check helps employers to make safer recruitment decisions by providing information about a person's criminal record and whether they are barred from working with certain groups of people. The Registered Manager told us they were very particular about the staff they appointed stating, "We need someone who's caring. That's got to be there from the beginning. You can't teach that."

Staff files showed that any concerns about staff performance had been addressed immediately. The registered manager had taken disciplinary action against staff who had not delivered care safely.

Medicines were generally managed safely. Staff who administered medicines to people had received training.. Staff administered medicines safely, explaining what the medicines were and ensuring people had a glass of water to take their medicines with. Staff signed the medicine administration record (MAR) as soon as she they had been administered and locked the medication trolley in between each administration. On the front sheet of the residents MAR charts there were details of how the person liked to take their medicines. For example, "[Name] likes to take her tablets one by one in her hand with a glass of water, and "[Name] likes to take her tablets together on a spoon with a drink and then take her [medicine]."

Staff followed good practice in the administration of creams and lotions. Each person had a record of administration which contained a body map. The areas of the body needing cream had been highlighted which minimised the risk of error. Staff signed to confirm they had administered cream and these records were checked by the senior daily.

We identified some areas of medicines practice which could be improved. One person who moved into the home the day before our visit needed their medicines 12 hours apart. This was not made clear on the MAR. We raised this with the registered manager and this information was added to the afternoon handover to ensure staff knew about this. The person's records were updated. One person had not received their pain relief patch and there was no record on the MAR about why this had not been given. We raised this with the registered manager who told us, after checking with the member of staff who had been administering the patch, that the person had refused but she had forgotten to record this on the MAR. The registered manager sent us a copy of their investigation and action plan following the inspection.

We observed staff assisting a person to take their asthma inhaler using a device intended to improve the inhalation of the medicine. This is used for people who find it difficult to master the metered dose inhaler technique either through physical or cognitive limitations. The method the member of staff used was not effective and we brought this to their attention as there was a risk people would not get this medicine effectively.

We recommend the provider reviews their medicines administration procedures in line with current published guidance.

Both medication trolleys had large black plastic sacks tied to the handle which were full of wipes, empty medication boxes and empty foil medication strips. The member of staff told us they used the sacks for throwing away used medicine pots plus other rubbish but was unsure how long they had been there. We identified this as an infection control risk and spoke with the registered manager.

People told us they were happy with the cleanliness of the home and their rooms were cleaned daily. One person said, "The cleaner is lovely, she cleans my room and shower every day she leaves it immaculate." A visitor told us, "When I visit the home it is always clean, I pass the kitchen and I can see that it is spotless, my [relative] tells me the cleaner comes in every day and they always have a laugh and a chat together." The premises were clean, cleaning schedules and records were updated throughout the day when tasks had been completed. Staff washed their hands frequently. Personal protective equipment such as gloves and aprons was available. The deputy manager on shift checked everyone's bedroom daily to ensure it was clean, tidy and that staff had carried out necessary tasks. Records showed that staff had to return to carry out further cleaning if checks found it was not good enough. The registered manager addressed this with staff if they had concerns about their performance. The provider had been awarded four stars by the Food Standards Agency.

The provider learned lessons and made improvements when things went wrong. Staff completed incident forms which were reviewed by the registered manager. People's care plans were updated to reflect any changes needed following an incident.

Staff at the service had a good understanding of people's individual communication needs. People's records contained clear information about any sensory impairment and directed staff on the best way to communicate. The provider told us about a married couple who were to live together at the home. They had arranged for them to have a shared bedroom and a private sitting room.

The provider had undertaken risk assessments of the environment which included a fire risk assessment in February 2018. Staff carried out regular fire drills and tests of alarms. Each person had an emergency evacuation plan which contained their photograph and information about their mobility. The registered manager was currently updating these plans. The provider had policies and procedures in place to ensure continuity in the event of the premises becoming unsafe due to unforeseen circumstances. There was a reciprocal agreement with another local care home to provide emergency temporary accommodation for people.

The cupboard which stored potentially hazardous chemicals such as cleaning fluids and other chemicals was not locked. We raised this with the provider who took action. We received evidence following our inspection that there was now a lock on the door.

Good

Is the service effective?

Our findings

During the comprehensive inspection in July 2016 we found a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations (2014), because staff had not always received suitable training to carry out their role. At this inspection we found improvements had been made.

People told us they felt staff were well trained, capable and competent to look after them well. Comments included, "Staff vary in efficiency, but all are capable of doing their job and doing it well, I have confidence in them all" and, "They are efficient and very kind, most are extremely good." A visitor to the service told us, "We have a good relationship with staff, they are excellent, they keep a watchful eye on my [relative]."

Staff told us they had the right qualifications, skills, knowledge and experience to meet people's needs. They said they received a lot of training during their induction in particular, and could access further training as necessary. Staff started the Care Certificate as part of their induction. The Care Certificate is a nationally recognised standard which gives staff the basic skills they need to provide support for people. Staff told us they were a "good team" and worked well together. They said they provided each other with day to day support. There was evidence of regular supervision in staff files, although this was less frequent for some staff.

People's care files contained an assessment form called a 'Trigger Tool'. This form enabled staff to identify the point at which they should refer people for additional health support. For example if a person had fallen twice the tool directed staff to contact the district nurse, two hospital admissions within the month to refer to the community matron. Staff were also given criteria for referral to the GP. The form ensured staff were able to refer people to the most suitable health professional in a timely manner.

Everybody had a completed 'Hospital passport' which was up to date. This included information about a person's preferences as well as their health and communication needs to inform hospital staff if they needed care in hospital.

People were supported to have sufficient to eat and drink. People told us they had plenty to eat and usually did not need extra snacks. One person had a fridge in their room for treats brought in by family. People told us, "The meals they provide are just like home cooking, it is the sort of thing people of this age are used to eating" and, "Food on the whole is very good, a bit plain, there is always a choice, and I can find something I like." Another person said, "Food quite good, I enjoy my dinners, soup and a sandwich for tea which I usually save and eat later."

We observed lunchtime. The dining room was bright with a convivial atmosphere. Staff provided wet wipes so that everyone could clean their hands before eating. People had tables with condiments and flowers on the tables, and staff ensured they were seated in a comfortable position to eat. Staff offered people juice or water to drink. People had preselected their meal, although they were offered an alternative if they changed their mind. One person did not want either of the main meals so staff offered a sandwich. Staff asked people if they needed help before doing anything, for example they asked people before helping them to cut up

their food.

The provider had introduced breakfast in the dining room in order to improve people's food intake and provide another opportunity for social interaction. This included a cooked breakfast once a week. People had previously eaten breakfast in their bedrooms. Since the introduction of breakfast in the dining room people had gained weight. Visitors to the service told us that since their loved ones had been at the home they had regained weight lost previously. One person had been refusing to eat and was malnourished when they moved in. Their relative told us that due to the care and gentle persuasion from two of the carers gradually they began eating and now ate a normal diet.

Staff used the Malnutrition Universal screening Tool (MUST) to help monitor people's health and nutritional support needs. MUST is a five-step screening tool to identify adults, who are malnourished, at risk of malnutrition (under nutrition), or obese. It also includes management guidelines which can be used to develop a care plan.

Staff used information in people's care records to help them monitor and manage specific healthcare needs and conditions and made suitable referrals. There was regular contact with GPs, District Nurse teams and other community specialists which ensured health and wellbeing needs were met. Visiting professionals confirmed contact was made quickly and appropriately when people's needs changed. One health professional told us, "Staff are straight on the phone if there's a problem." People were supported by staff to attend specialist appointments. Staff completed evaluation sheets following any change in a person's health or any visits by health professionals. These records were clear, comprehensive and communicated relevant information.

Staff sought consent before any intervention asking people, "Would you like me to....?", or, "Can I....?Is it alright if I....? Can I do [task] for you? "People confirmed this was normal practice and staff always asked.

People told us staff encouraged them to make choices, for example what to wear. A visitor told us, "Staff help my relative select what they are going to wear by holding things up and saying, "What about this today" but allow her the final decision." Staff encouraged people to take part in activities and to eat in the dining room but respected their decision to remain in their room if they chose. One person told us, "I get up when I am ready; I prefer to have my breakfast and tea in my room but go to the dining room for my lunch; when there is some activity going on I usually join in, other than that I stay in my room, nobody tries to persuade me to do anything different." A visitor said, "My relative likes to spend time in their room because they can do what they please, staff check they are alright, then leave them."

Staff had received training in the Mental Capacity Act (MCA) 2008 and were able to demonstrate their understanding. 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 MCA 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.

The Registered Manager and staff told us that many people had capacity to consent to care and treatment. People had signed consent forms for personal care, medicine administration and photographs. The registered manager and staff were able to describe how to support people to make decisions. People's care records contained comprehensive best interest decisions if they had been needed. Staff had received training in the Mental Capacity Act 2005 and told us they assumed people had capacity to make decisions unless an assessment and best interest decision had been made.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals 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.

The registered manager had a record of all applications made under the Deprivation of Liberty Safeguards (DOLS). These had been completed and sent to the local authority. Nobody at the home had an authorised DOLS

One person's records contained a signed 'Advance Wishes for Care' document. This made clear to staff the person's choice about where they wanted to be and how they wished to be treated if their condition.

The service was in a large converted Victorian building. The provider had made adaptations such as installing a lift and stair lifts were available in case the lift was out of action. The service had a homely feel and people had access to two lounges, a conservatory and a large dining room which was large enough for everybody to eat there. Adaptations and modifications had been made where possible to promote people's independence. This included the use of signage, ramps, lifts and stair lifts throughout the building. Visiting health professionals told us they thought some of the rooms at the very top of the building were too distant from other people and activities taking place. However, this had not been raised by Oaktree staff or people living in the home. There were limited private spaces for people to spend time with visitors, other than in their bedroom. Routine activities took place in a small lounge area, and staff reported that larger events happened in the dining room.

Good

Is the service caring?

Our findings

People and their relatives were complimentary about staff and the care provided by the service. A relative told us, "Staff are very caring; we have been called on two occasions when [name] has been agitated, and found a carer sitting holding [name's]'s hand quietly reassuring her." Comments from people included, "Staff are caring, they do the things for me that I cannot manage myself. They are very busy but will listen and give you time when you need to talk" and, "The staff are lovely, they treat me as if they were my mother, they know me well, they know if I am poorly before I do." A second relative told us, "The staff are excellent, they have got to know my relative well and thanks to them her anxiety has gone and she has returned to her old self and has started 'living' again and has a new lease of life, enjoying reading and listening to the radio. My relative is very happy here, after being in three other care homes she made the decision to stay here as it felt homely."

People looked well cared for, with clean clothes, hair and fingernails. They were dressed appropriately to reflect their age, gender and previous lifestyle. Staff interacted with residents in a friendly caring and compassionate manner; it was apparent that staff knew the residents well and their likes and preferred choices. Staff spoke to residents using appropriate volume and tone of voice, there were signs of affection and terms of endearment were used appropriately with positive reaction from residents.

Staff treated people with dignity and respect. People told us, "I feel comfortable with personal care, they are respectful and thoughtful." There was a calm atmosphere within the home, and one staff member described the atmosphere as, "Friendly, relaxed and caring". We asked one person if they were happy living at Oaktree House and they replied, "As happy as you can be. It's not home, but it'll do." Staff we spoke with said that they enjoyed working in the service.

Staff explained what they were going to do with people to reassure and support them during moving and transferring. For example, we saw staff support one person with accessing the toilet. They were very respectful of their preferences and patiently explained where they would be and how they would assist them to prevent them from becoming anxious.

People had not always signed their care plans but the majority had participated in care reviews. None of the people we spoke with were able to tell us about their care plan but we were told, "I have not been involved in my care plan, I was so poorly when I came I expect my family did it, I leave everything to them and they liaise with the office on my behalf" and, "I do not remember being involved in my care plan but I am a determined person and would speak my mind if something was not to my liking."

People were able to attend residents meetings to contribute to the running of the service. People were able to give feedback on the menus and make requests. Staff discussed upcoming activities and possible services. For example, people were asked if they would like the mobile library to visit.

People's privacy was respected they confirmed staff always knocked prior to entering their room, and ensured the door was closed and curtains drawn before they commenced any personal care. People were

encouraged to be as independent as possible and to maintain their skills. For example, during lunchtime staff supported people to eat, but also left them for brief periods and encouraged them to eat what they could without assistance. Another person managed their own medicines which they kept in their bedroom.

Good

Is the service responsive?

Our findings

People received support that was personalised to their needs. Staff carried out individual assessments of people's physical, mental health and social needs. Care plans were detailed and holistic and reflected people's preferences in order to guide staff how to deliver care. Plans were reviewed monthly and updated when people's needs or preferences changed. One person's care plan contained information about their communication, "I am often very quiet and do not always respond when spoken to. I may smile at you then whisper a reply." Their care plan for personal care stated, "I have recently been getting up later which has had a positive effect on my whole day. I no longer wish to have a bath or shower due to my anxiety. I now like a full body wash." Another person's personal care plan said, "I have arthritic conditions which means I am stiff and in pain sometimes and cannot walk sufficiently. I have a turn aid with a sling which I am willing to use. Please brush my hair and give me oral hygiene before I go to the dining room." People were able to specify the gender of the member of staff delivering their personal care. This information was specified on the shift handover sheets.

Staff worked with the district nurses and GP to support people at end of life. The registered manager showed us a plan that had been in place for a person who had since passed away. Staff completed food, fluid and turn charts for the person. The district nurses came in to ensure the person had pain relief and family members were able to visit at any time.

The service had a monthly programme of activities; activities for the day were listed on a notice board in the hallway. Significant dates and holidays were celebrated, for example, in the previous two days, people had celebrated Shrove Tuesday with pancakes, and had a special Valentine's Day meal. Staff went out with people locally, whenever there was something of interest happening. One person told us a member of staff took them out in a wheelchair to buy knitting wool.

The provider bought in a wide range of activities which included musical entertainment, mixed interactive activities, yoga and cardio exercise groups, visits from zoo staff who brought small animals for residents to hold, art sessions, a knitting group, quizzes, film shows and bingo. There were regular visits from a hairdresser. On the morning of our visit there was entertainment in one of the lounges, with musical activities and a quiz. All residents were encouraged to participate, those attending appeared to enjoy the session. People told us, "There is quite a lot of entertainment, I love it when the animal zoo comes, I hold the animals and stroke them" and, "It [the entertainment] has cheered me up, I think it was wonderful." Visitors to the service told us, "My relative is very sociable and usually goes along when there is some entertainment, but is content to sit in her room and read or watch TV." A visitor also said, "I know there are activities, but I feel there is a lot of sitting around with nothing, the television is always on but my relative does not really watch it."

Staff were proactive in finding out more about the interests and preferences of the people who chose not to take part in the activities which were being provided. Staff had identified people who regularly chose not to engage, and had focusing on their interests, asking them more about what they would like to do. Staff told us they would like to be able to support people to access community facilities more. Some community links

were in place such as a local cinema which held a film night and some people went out to a weekly lunch club.

People said they had not needed to make a complaint but would feel able to do so. One person told us, "If I had a problem I would talk to a member of staff, it wouldn't worry me and I wouldn't be frightened to do it." The provider kept a log of complaints and records showed complaints had been responded to. The registered manager showed us some of the cards and feedback from family members. The majority of these cards thanked the staff for their love, care and kindness. Staff told us that they knew how to make a complaint or raise concerns. They stated they would feel confident to do this, particularly if an issue related to care or safety. Staff told us they could speak with the Registered Manager at any time.

Good

Is the service well-led?

Our findings

During the comprehensive inspection in July 2016 we found a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations (2014), because the provider did not have a comprehensive system of audits which identified shortfalls in the service. At this inspection we found improvements had been made.

There was a friendly caring atmosphere at the home, the provider was much in evidence and observed interacting with people and staff. People told us, "The managers are very friendly, they keep a close eye on what is going on" and, "The managers pop in and out of my room, they will always have a quick chat and make sure everything is alright." A relative told us, "I find the owners and manager to be very approachable, they let us know what is going on because we can't rely on what [name] tells us as being a true fact." Another person said, "I never see the managers or if I do I don't recognise them."

There was a management structure in place which was clear and the senior staff team were visible around the service. The registered manager, two directors and a deputy were present at Oaktree House throughout the inspection. We were informed that their presence was usual, and staff felt adequately supported to provide a quality service.

The registered manager was very aware of the day-to-day culture in the service, and worked hard to ensure this was positive and person centred. One staff member noted that, "[Name] has made it much more person centred. It's really different to what it was like before. Much better." The registered managed explained that they had made focused changes when they were not satisfied with staff attitudes or behaviours.

The staff team was supportive and worked well together. Staff helped each other with more challenging tasks and shared responsibilities. Staff told us that they were a small enough team to know each other and know how to work together. One staff member said "we're a good bunch really. We're a good team, and there aren't really any problems."

We spoke with the directors who told us they told us they aimed to provide a friendly and homely home which they were confident they had achieved. The providers knew the people living at the home and their relatives. They gave an example of adapting one bedroom to become a sitting room for a married couple to demonstrate how they aimed to provide what people needed. Another example was the introduction of breakfast in the dining room and the positive difference this had made to people in respect of weight gain and well-being.

The directors told us they had confidence in the registered manager and there was a good staff team working in the service.

There was a comprehensive governance system in place. The registered manager had introduced clear lines of responsibility and reporting structures. Staff signed task sheets to confirm they had completed their allocated work. The registered manager checked with staff at the end of the shift if they had signed all their

work off. The deputy manager and senior were responsible for ensuring all tasks had been completed. Checks of all rooms were carried out. If staff had not completed care to an acceptable standard this was addressed in supervision and an action plan developed. The registered manager checked on progress at the next supervision.

Staff received training and supervision and the provider had a system to monitor this. The registered manager addressed any staff performance issues in a timely way. Records showed that an action plan was developed and followed up to ensure improvements in performance had been made.

People said they were informed of what was happening and were asked for their views and suggestions. There were regular residents meetings, chaired by the manager. People told us the registered manager listened to what they said, although none could give an example of this, or recall any changes as a result of suggestions. Only one relative could say they had completed a questionnaire, and one resident thought that maybe a family member might have.

The registered manager had a working relationship with the local safeguarding team and commissioning groups. The wider staff team worked well with local health and social care services and multidisciplinary teams which ensure care was joined up and people's needs were met.

We checked the provider's quality assurance systems for the domiciliary care service and were satisfied that the service had been run effectively. There were systems in place to ensure people received person-centred care and that calls had not been missed. The provider had undertaken a quality survey with people used the service and all had been satisfied. We spoke with people using the service who were all very complimentary about the staff and the care they received.

We spoke with the coordinator of the domiciliary care service who described the system of supervision and spot checks. Records confirmed these had taken place. People using the service had all been notified the service would cease. The coordinator was able to confirm everybody had alternative arrangements.