Oakland Court Limited

# Oakland Court

## Inspection report

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## Ratings

| | |
|---|---|
| Overall rating for this service | Good |

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|---|---|
| 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 took place on 13 and 14 March 2018 and was unannounced.

At the last inspection, the service was rated Requires Improvement overall and in each domain apart from Caring and Responsive which were rated Good. The rating of Requires Improvement was awarded in relation to the storage of medicines, arrangements to prevent avoidable accidents, support for people with their nutrition and hydration, safe recruitment systems and audits. At this inspection, we found that steps had been taken to address all these issues and the rating has improved to Good in each domain and overall.

Oakland Court is registered to provide accommodation and care for up to 37 older people with a range of needs. At the time of our inspection, 34 people were living at the home. Communal areas include a dining room, lounge leading to a large conservatory, additional conservatory area next to the reception and accessible, landscaped gardens. All rooms are en-suite and accommodation is over three floors serviced by a lift. Oakland Court 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.

A registered manager was 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.

Medicines were managed safely. Risks in relation to people and in the management of premises had been identified, assessed and were managed satisfactorily. People felt safe living at Oakland Court and staff had been trained to recognise the signs of potential abuse and knew what action to take. Staffing levels were assessed based on people's care and support needs. Robust recruitment systems were in place. Lessons were learned when things went wrong and case conferences provided opportunities for issues to be discussed and improvements made. The home was clean and odour free; effective infection control systems were in place.

People's risks in relation to nutrition and hydration were monitored and steps taken to ensure people maintained a healthy lifestyle. Healthcare professionals and services were available to people as required. Menus offered people a range of choices at mealtimes and people were involved in the planning of menus. Staff completed a range of training considered essential for their role and received regular supervisions with an annual appraisal. People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice.

People were looked after by kind and caring staff who knew them well. Positive and meaningful relationships had been developed. People were encouraged to express their views and to be involved in all

aspects of their care. Their privacy and dignity were maintained.

People received care that was person-centred and responsive to their needs. Care plans were detailed and provided guidance to staff about people, their likes, dislikes and preferences. Monthly review meetings were held with people to discuss their care and information was available in an accessible format. Staff completed equality and diversity training and understood how to treat people as individuals. People's spiritual and religious needs were catered for. Activities were organised and were varied. Complaints were addressed in line with the provider's policy. People could be cared for until the end of their lives at Oakland Court and had access to appropriate healthcare support.

Audits were robust and identified any areas for improvement so that actions could be taken. People and staff were complimentary about the management of the home. Residents' meetings took place and people felt their views were listened to at meetings and through questionnaires they completed. Staff were also asked for their feedback and felt supported in their roles. People were happy with the quality of care and life at Oakland Court.

## 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.

Medicines were managed safely.

People's risks had been identified and assessed appropriately with clear guidance for staff on mitigating risks. Audits were completed with regard to premises and servicing of gas, electricity and equipment was undertaken.

Safe recruitment practices were in place and staffing levels were within safe limits.

People felt safe at the home and staff had been trained in safeguarding adults at risk. Lessons were learned when things went wrong.

The home was clean and effective infection control procedures implemented.

### Is the service effective?

Good

The service was effective.

People's hydration and nutrition needs had been assessed and were managed effectively. People enjoyed the food on offer at the home.

Staff completed a range of training and had regular supervision meetings and an annual appraisal.

People had access to a range of healthcare professionals and services.

The service worked in line with the legislative requirements of the Mental Capacity Act (2005) and Deprivation of Liberty Safeguards.

### Is the service caring?

Good

The service was good.

People were looked after by kind and caring staff. They were involved in decisions and choices relating to their care.

People were treated with dignity and respect.

## Is the service responsive?

Good

The service was responsive.

People received personalised care and were involved in reviewing their care plans. Care plans provided detailed information and guidance to staff about people, including their personal histories.

A range of activities was on offer to people and occasional trips into the community were organised.

Complaints were managed in line with the provider's policy.

The home tried to ensure that people could remain at the home until the end of their lives, if this was their wish.

## Is the service well-led?

Good

The service was well led.

A range of robust audits monitored the service and identified any areas for improvement so that action could be taken.

People felt involved in developing the service. Their views and feedback was sought through residents' meetings and questionnaires.

People spoke highly of the management and staff and felt they received a high quality of care at the home.

Staff felt supported by management who were readily accessible.

# Oakland Court

**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.

The inspection took place on 13 and 14 March 2018 and was unannounced. The inspection team consisted of three inspectors 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. Their area of expertise included older people and dementia care.

Prior to the inspection we reviewed the information we held about the home. This included information from other agencies and statutory notifications sent to us by the registered manager about events that had occurred at the service. A notification is information about important events which the provider is required to tell us about by law. We used all this information to decide which areas to focus on during our inspection. The registered provider had completed a Provider Information Return (PIR). The PIR is a form that asks the registered provider to give some key information about the service, what the service does well and improvements they plan to make.

During the inspection we spoke with 12 people who lived at the home, one relative, a visitor, the chief executive, the registered manager, chef, care co-ordinator, lead senior, three care staff including one who also arranged activities and the maintenance man. We also spoke with a visiting health professional.

We spent time observing the care and support that people received and also observed a member of staff administering medicines to people.

We reviewed a range of records about people's care and how the home was managed. These included five care records and medicines records. We also looked at staff training, support and employment records, audits, minutes of meetings, menus, policies and procedures and other records relating to the management of the home.

Good

# Is the service safe?

## Our findings

At the inspection in January 2017, we found concerns relating to the management of medicines, the protection of people from the risk of avoidable accidents and background checks in the recruitment of new staff. The provider was not asked to complete an action plan as there were no breaches of Regulation. However, the registered manager developed a plan to identify areas in need of improvement, to monitor progress and to address the issues found at the last inspection.

The medicines audit had not been completed in a robust manner when this was checked at the last inspection. There were issues in relation to the storage of medicines to ensure the correct temperature was maintained. At this inspection we found improvements had been made and that the monthly medicines audits were completed satisfactorily. Readings were taken of the temperatures in the room where the medicines trolley was kept and within the refrigerator; these were within acceptable limits. The pharmacy who supplied medicines had completed an audit and no issues were identified. When medicines were received, two staff checked and signed them in. In the past, there had been a number of medicines errors. The provider had looked at the management of medicines and made the decision to change the issuing pharmacy. Staff had completed training in the administration of medicines and their competencies were checked. A member of staff was 'Medicines Champion' which meant they had completed advanced training in medicines and was the 'go to' person if any staff member had any queries or wanted advice. We looked at the storage of medicines and saw these were well organised with dates of opening recorded on oral suspensions and topical creams in line with good practice. We observed one member of staff administering medicines to people at lunchtime. This was done competently and the staff member spent time with people to ensure they had taken their medicines as required. Medicine Administration Records (MAR) had been completed as needed.

People told us they received their medicines as prescribed. One person said, "Medication is given when it should be" and another person told us, "Yes, I get my medication regularly".

At the last inspection, we found there was a shortfall in one of the arrangements that had been made to prevent people from experiencing avoidable accidents. On one of the flights of stairs, there was only a flimsy barrier made out of a length of cord that was suspended across the top of the stairs that led to a fire escape door. Improvements had been made and a rigid stairgate had been placed at the top of the stairway. This could be removed quickly in the event of an emergency.

We spoke with the staff member in charge of maintenance and looked at health and safety and emergency arrangements in the event of a fire, for example. Gas safety, electrical wiring, portable appliance testing, lift service, hoists and slings, Legionella testing and fire alarms had all been managed safety and we looked at records in confirmation. Staff had been trained in fire safety and the training company provided quizzes and workbooks which staff completed. A 'Fire Working Group' had been convened at which all aspects of fire safety were discussed. Alarms and emergency lighting were routinely tested and audits completed to show that all necessary checks had been made. We saw that restrictors had been fixed to windows and radiators had been covered, which helped to ensure people's safety around the home.

People's risks were identified, assessed and managed safely. The registered manager told us that people's choices and independence were encouraged. For example, some people chose to make their own beds. Records showed that risks in relation to nutrition, skin integrity, falls, behaviours, swallowing and moving and handling had been completed. Each risk assessment identified the hazard, who was at risk, the control measures in place and an implementation plan. Where needed, people were referred to health professionals, for example, to a speech and language therapist for swallowing difficulties. Staff had completed training in relation to falls and of people's risks in developing pressure areas. The registered manager told us, "Staff complete observations when delivering personal care and report any concerns. I am sure we deliver a good service". The software system that the provider had recently introduced reminded staff when a risk assessment needed reviewing. Staff had completed training in moving and handling and people felt staff were competent in moving them safely. One person said, "When staff help us to move about, they are very gentle and careful about it". Another person told us, "I use a walker and for now, I am allowed to use the lift to go downstairs on my own".

At the last inspection, we found two instances where the provider had failed to obtain a suitably detailed account of the applicant's employment history and why they had left previous jobs in care. We looked at the recruitment records for three staff members and all the necessary checks had been completed in relation to the obtaining of references, Disclosure and Barring Service (DBS) checks and employment histories. The registered manager said, "No-one can start without clean checks and a DBS. Whenever someone starts, I will question their past histories". The care co-ordinator told us, "We over-recruit. We do use agency to some degree, but this is not our preferred situation. Staff will do overtime if needed". The chief executive said, "Recruitment is a constant issue in our sector, but we have good recruitment systems and processes. I think recruiting the right people is important, because I don't think everyone sees care as a career necessarily. It's better to recruit the right person in the first place and train them up".

Staffing levels were within safe limits. Seven care staff worked in the mornings and six in the afternoons, with three waking night staff. Staffing levels were assessed based on people's care and support needs. Most people we spoke with felt there were enough staff on duty and that the responses to call bells were within a reasonable time. One person said, "Generally there are enough staff about and there are no staffing problems at weekends". Another person told us, "They definitely do respond to calls for help quickly. When I used the call bell in an emergency, they responded very quickly". One person felt there were not enough staff but could not qualify this statement. However, they added, "I use the call bell for help and the response is quite good".

Staff had completed training in safeguarding adults at risk, could identify the types of abuse they might encounter and knew how to report any concerns they might have. A copy of the local authority's multi-agency safeguarding policy was available for staff to refer to. We discussed safeguarding concerns that had been raised prior to the inspection. The chief executive had a good understanding of the concerns and was able to demonstrate that the issues had been dealt with satisfactorily. Actions had been taken and lessons learned. A healthcare professional told us, "It's a learning curve for everyone and putting structures in place to make sure it doesn't happen". People told us they felt safe living at the home. One person said, "I do feel safe and I do get what help I need". Another person told us, "Oh certainly I do feel safe here. It's because they look after me so well.

Lessons were learned and improvements made when things went wrong. In addition to the learning in relation to safeguarding issues, case conferences were organised where incidents were discussed. Relatives could also attend these case conferences if an issue was being discussed that related to their family member. The registered manager told us of an incident relating to medicines and that the staff member had been re-trained and their competency re-assessed.

People's rooms and communal areas were kept clean and were odour free. During an outbreak of Norovirus in the winter, the home was closed to visitors. A healthcare professional told us of the barrier techniques used to prevent the spread of infection and the effectiveness of washing facilities and hand sanitisers around the home. An Infection Control Working Group was set up and the housekeeping and care staff met up from both the provider's homes to share good practice. The chief executive completed an annual statement on infection control and said, "There's a lot of shared practice and trying to involve other members of staff. It's not just the manager or care co-ordinators". People commented on the cleanliness of the home. One person said, "I think it's lovely. We're lucky to live here. Everything is clean". Another person told us, "You won't find a cleaner place".

As a result of improvements made and the findings at this inspection, the rating under 'Safe' has improved to 'Good'.

Good

# Is the service effective?

## Our findings

At the inspection in January 2017, we found concerns relating to the arrangements to support two people to have enough nutrition and hydration were not robust. We discussed the issues raised with the registered manager. Improvements had been made in the recording of people's food and fluid intakes and the new software flagged up any risks in relation to people's nutritional and hydrational needs. Following the last inspection, every person was reassessed and risk assessments put in place in relation to their food and fluid intake. One member of staff on each duty monitored the fluids and snacks for people and everything was recorded. People were encouraged in their fluid intake and were offered hot drinks, squash, water, smoothies and jellies. The registered manager told us, "Staff are very good at highlighting issues, for example, when a person is not feeling well and not eating or drinking enough". Ten people had been assessed as needing specialist diets, for example, required a high calorie diet to maintain or increase their weight. The chef explained that they added cream or butter to fortify meals. The chef also knew people's likes and dislikes and any allergies. When asked about the texture of food, the chef said, "Pretty much all the food is soft, so people don't have problems with it". People had a choice from the menu and the chef said, "If people want something different from the menu, they can order it". The main meal was served at lunch time. Menus were planned over a four weekly cycle and people chose from the menu the day before, with a chance to change their mind when their choice was served, if they wished. Changes to menus were planned with people at residents' meetings.

We observed people have their lunchtime meal on the second day of our inspection. Twenty-three people sat at tables in the dining room and all were eating independently. Three members of staff were serving meals and wearing protective aprons. Some meals were delivered to people in their rooms and staff provided assistance to people where needed. People's choices were discussed with them as the meal was served and people told us they had enjoyed the meal. The chef told us of people's involvement in choosing a particular brand of sausage and how five different types had been tried and tested. People chose the one they preferred and this was now being served. People also had differing ideas of when supper should be served; some preferred to eat at 5.30pm and others later. The chef had extended the times when supper was served so people's preferences were accommodated. We saw that drinks were freely available throughout the day. The majority of people enjoyed the food on offer. One person said, "They come round and ask what you want for lunch and choices and you can ask for something different if you want". Another person told us, "We have pre-lunch drink [usually sherry] every day. Breakfast is served in our rooms and it suits everyone". Out of 12 people we spoke with, only one person made a slightly negative comment and said, "Sometimes the meals are very nice, at other times not so good".

People's health and social needs were holistically assessed and a visiting healthcare professional confirmed this. They explained the different assessments in use, for example in relation to nutrition using the Malnutrition Universal Screening Tool (MUST), a tool specifically designed for the purpose. The healthcare professional said, "They're very much on the ball with things". They told us about people who were being treated for pressure areas and about specialist equipment that was brought in to help people. The healthcare professional told us, "This is one of the better homes I deal with. Carers are all smart and very professional. They understand the need to refer people where required. The manager is very on board and

they provide the best care here". The registered manager explained the importance of staff reading the provider's policies and procedures and how this contributed to people receiving a good standard of care and support. They told us, "We talk about policies at staff meetings and handovers and any changes that have been made. Experiences make the policy come alive".

Staff completed training considered essential to the role, for example, moving and handling, infection control, malnutrition, safeguarding, continence and dementia. Training was refreshed two yearly, yearly or six monthly, depending on the training topic. Training was planned for the year ahead and staff were reminded when they needed a training refresh on any particular area. We looked at the staff training plan which showed the training staff had completed. New staff completed an induction programme, had a probationary review and studied for the Care Certificate, if they had no previous qualifications in health and social care. The Care Certificate is a universally recognised vocational qualification which is a work-based award. Staff we spoke with found the training helpful. One staff member said, "We have loads of training every year. It includes dementia awareness and mental capacity". People felt that staff had the skills and training they needed to provide effective care. One person said, "All staff seem good at their jobs". Another person told us, "Some new staff are being trained, but there are plenty of other fully trained staff". Staff had supervisions with their line managers every couple of months and an annual appraisal. The registered manager explained the annual appraisal process and said, "I will ask staff about their areas of need and it's a sort of plan. We also discuss the importance of separating work from home life".

People were supported to live healthy lives and had access to a range of healthcare professionals and support. At the time of our inspection, a community matron was visiting three times a week to support new staff. They had delivered wound care training and supported staff in the management of pressure areas. They said, "I would definitely say I would support staff with anything, they're brilliant". People received visits from GPs and paramedic practitioners as needed; a paramedic practitioner was visiting when we inspected and it was evident they knew people well. Hospital appointments, chiropodist visits and eye checks were recorded in people's care records. One person said, "If you want the doctor, they will call him". Another person told us, "If you need to see the chiropodist, they will organise it". A visitor, referring to their friend who lived at the home, said, "She does get all the medical services".

The home provided a warm, comfortable environment for people. A staff member said, "We try as much as possible to make it home from home. If people want to bring their own furniture, they can do". Ramps provided easy access to landscaped gardens and people could be involved in gardening, with support, if they chose to.

We checked whether the service was working within the principles of the Mental Capacity Act 2005 (MCA) and whether any conditions on authorisations to deprive a person of their liberty were being met. The MCA provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. 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 and hospitals are called the Deprivation of Liberty Safeguards (DoLS). Some people were subject to DoLS, but there was no 'locked door' policy at the home and people were free to leave if they wished. The registered manager told us that some people were living with early onset dementia and said, "We continually reassess and try and keep people", as Oakland Court is not a specialist dementia home. Capacity assessments had been completed where needed. Some people had appointed representatives to act on their behalf as their Lasting Power of Attorney (LPA), but it was not always clear from the care records whether this was in relation to health and

welfare and/or property and affairs. We discussed this with the lead senior, who stated they would go through all the documentation in relation to LPA and record in what areas the LPA related to, to provide clarity.

Staff had completed training on MCA and DoLS. One staff member told us this was important for people living with dementia if they could not make some decisions for themselves and how a best interests' decision might need to be made. They told us, "We promote independence as long as people are not at risk of harm, so we have the principles of MCA in our minds all the time". People told us they were involved in decision-making. One person said, "Oh yes, I am always involved in decisions about me and my care".

As a result of improvements made and the findings at this inspection, the rating under 'Effective' has improved to 'Good'.

Good

# Is the service caring?

## Our findings

People and relatives said the care was of a high standard and thought that staff were kind, caring, helpful, attentive and respectful. Positive relationships had been developed. This was evident through our observations at inspection. Staff were heard to use people's preferred names and we saw that people were appropriately dressed for the time of year and well groomed. We asked people what they thought about the staff and whether communication was effective. One person said, "All staff are lovely, helpful and attentive". Another person told us, "Staff are very nice, helpful and sociable". A third person said, "Staff are very good and patient. They communicate with you if you want information". Throughout our inspection, we observed staff interactions with people and, without exception, these were positive and appropriate. We observed one person wanted to go into the garden for some fresh air and a staff member immediately offered to get their cardigan from their bedroom. People were promptly assisted when they asked for help and did not have to wait for support. The atmosphere of the home was relaxed and calm. We observed people spending time in the sitting room after lunch; some were reading newspapers or a book and others were having a chat or watching television. At 3pm, hot and cold drinks and a choice of cake were served. People were welcomed into the office, situated next to the front door, to pass the time of day with staff or raise any issues they wanted to discuss. A staff member told us, "If someone seems alone, a staff member will sit with them. We recognise there's an emotional side to care, it's not just the physical".

People were supported to express their views and to be involved in making decisions about their care. People felt involved and one person said, "Most of us feel we can be independent. You can go out on your own, but you can ask for someone to go with you". Another person told us, "All my details are in my care plan and I think I have been asked to sign it sometimes". People felt their preferences were taken account of and their choices listened to. One person said, "We do have choice, like going to bed when we want to". A second person told us, "I have choice, like being here in my room or in the lounge. It's my choice about being in my room a lot". We looked at whether people's communication needs were taken account of and how staff sought accessible ways to communicate with people in relation to decision making. Everyone we spoke with had a clear understanding about their care needs and felt involved in decisions relating to their care.

People's privacy and dignity was preserved and they were treated with respect by staff. One person said, "Staff give us respect, like shutting doors and drawing curtains when dealing with us". Another person told us, "They are kind and respectful and respond to my requests". A third person said, "I like the male carers to shower me and they make sure this happens. On the one occasion when it didn't, the female member of staff was excellent, very sensitive and proficient".

People and their relatives were also asked what they thought in relation to, 'Your privacy at Oakland' and there were 27 responses. People were asked whether staff knocked on their door, waited to be invited in and had a say in the care they received. The responses were overwhelmingly positive. People also stated they had privacy so they could meet and talk with their GP.

Good

# Is the service responsive?

## Our findings

People received care that was responsive to their needs. We looked at a number of care plans and people's needs in relation to their nutrition and hydration, communication, mobility, medicines, mental state, personal care and activities, all of which had been documented. From August 2016 all organisations that provide NHS care or adult social care are legally required to follow the Accessible Information Standard. The standard aims to make sure that people who have a disability, impairment or sensory loss are provided with information that they can easily read or understand so that they can communicate effectively. Where possible, people had signed their care plans to show their agreement. Monthly review meetings were held with every person who lived at Oakland Court and these were recorded. People's needs in relation to their mobility, nutrition, hygiene, medicines, mental state, activities, communication and night-time patterns were documented. Whilst people were involved in their monthly reviews, it was not always recorded how, within the care record. We discussed this with the registered manager who said they would make sure that staff recorded when and how a person was involved in their monthly review meeting. A staff member said, "I feel assessments are thorough and lead to accurate care plans. Sometimes we have a case conference about a particular resident, when they have changing needs, so care staff can give their suggestions how to provide care. We are involved in care plan reviews". Handover meetings took place at the end of each shift and we sat in on the lunchtime handover. Each person's care needs were discussed and an update given to staff coming on shift. These meetings were an effective way of communicating with staff and ensuring people's current needs were addressed and shared with staff.

Care plans were written in a person-centred way and daily records completed appropriately. New software had been installed and care records were in the process of being transferred into an electronic format. The registered manager talked about the advantages of the new software and said, "Staff document on the go, so now things are more likely to be documented than they were before". A staff member told us, "The new digital system is very good. It means records are updated as things happen. Everything is in the right place and we can share with residents what we are inputting. The 'red bells' highlight all the priorities at handover. Agency staff are given a hand-set with their own log-in, which means they have the same information as us and it also helps with induction of new staff". The new software could be developed to a point where staff could record a conversation with a person and involve them in the planning of their care in an accessible way. When people needed to be admitted to hospital, information relating to their health and care needs could be easily printed off. People's personal histories, likes and dislikes were recorded.

Staff had completed training in equality and diversity and understood the need to treat each person as an individual. One staff member said, "Whatever someone wants to do, they can do". People's spiritual needs were catered for. For example, a lay minister visited from a Roman Catholic church and met with people who wished it. The care co-ordinator took the inspection team through the list of current people living at the home. They demonstrated that they knew each person well, any sensory impairments they had, health conditions, diets and medicines, risks and people receiving end of life or palliative care.

The home did not have a dedicated activities co-ordinator, but was in the process of drafting a job description and had plans to recruit to this new post. During the week of the inspection, a visit was planned

for people to visit a local hall for afternoon tea. Other activities that were planned included armchair exercises, games and quizzes. Where people chose to remain in their rooms or were cared for in bed, then activities were arranged individually. There were links with the community, for example, a local college where people could visit for tea and involvement with the Rotary Club, We asked people about the activities on offer. One person said, "We have lots of activities like quizzes, which keep our brains alive. We have bingo and games and we used to have arts and craft. We occasionally have visiting entertainers". A second person commented, "They organise a daily newspaper, if you want it and it's 'open house' for visitors". A third person told us, "There is a good activities programme and I go to some of them".

Feedback from people and their relatives was encouraged and we looked at the providers policy in relation to complaints, which was clearly written. It stated, 'Where someone makes a verbal complaint, we will make a written record and provide a copy of it'. Reference was made to the Local Government Ombudsman and the Commission, who could be contacted if a complainant felt their complaint had not been managed satisfactorily. Individual complaint records showed the detail of the complaint, the actions taken and any emerging learning. Complaints we looked at had been managed appropriately. People knew how to make a complaint. One person said, "I don't have any complaints and I would say something if I was not happy about something". Another person told us, "No complaints at all and I've never complained".

During the inspection, the feedback register folder was reviewed. The home had recorded complaints and how the home had responded to these complaints. The registered manager understood the requirements under the Duty of Candour, to speak to those involved in an open and transparent way, to take responsibility for what had occurred and to take any actions needed to make improvements.

People were supported at the end of their life to have a comfortable, dignified and pain-free death. If possible, people could remain at the home and received support from healthcare professionals as needed, for example, from a local hospice. People received timely and prompt healthcare advice as the home was part of a local NHS initiative which enabled staff to have speedy input from district nurses when needed. A visiting healthcare professional was complimentary about end of life care at the home and said, "Staff are very good carers and great with the residents. They look after me when I visit too. They're polite and know every resident by name. Staff are very well informed". A member of staff said, "Families will often want relatives to stay here rather than go into hospital".

Following the death of their loved one, a relative had written, 'So appreciative of the care given to my mother – 24 hour care they gave her in the final days. It was superb and your team there are to be congratulated on their compassion and attention to all her needs, despite the fact that she very likely did not know in the last couple of days what was going on'. For one family, the registered manager called in a priest to administer the Sacraments of the Sick, which was important to the person and their family.

Good

# Is the service well-led?

## Our findings

At the January 2017 inspection, the concerns relating to medicines, avoidable accidents, recruitment checks and support with regard to people's nutrition and hydration needs meant that systems were not robust as these issues had not been identified through audits. This was an area identified as 'Requires Improvement'. At this inspection, we looked at a range of audits in relation to medicines, falls, staff files, health and safety, fire safety, infection control and checks in relation to the premises. Audits had been completed appropriately. We asked the registered manager how they could learn and improve based on the findings of audits. They said, "I'm very transparent and if something is wrong, I will have a case conference. Staff are welcomed and I will put up minutes for them to read". For example, a case conference might be called when people sustained a series of falls, how a referral would be made to the falls team and sensor mats be organised to monitor the person's movements in their room. The new software meant that a senior member of staff could check that care staff had completed charts with regard to people's food and fluid intake, or turning charts for people with pressure areas. An external consultant completed a series of audits around the home and identified any actions that might be needed to drive improvement.

People and their relatives were complimentary about the staff and management of the home. They commented that staff were very friendly, approachable and did listen. The registered manager was visible around the home and knew people well. One person said, "The management is a listening one and the office staff are very good".

People and staff were involved in developing the service. When new staff were recruited, people were asked if they wanted to help in the interview process. Residents' meetings were held and these were also open to relatives. The registered manager told us these were held, "As and when required, but at least twice a year. One resident missed a meeting because it wasn't on the activities list, so we gave her the notes and held another meeting two weeks later". After the last inspection, a meeting took place for people and their relatives so everyone could discuss the findings of the report, the ratings and what actions would be taken to address the concerns found. One person said, "There are meetings for residents and we do feel we can have our say at these meetings". Another person told us, "We do have residents' meetings and are given the opportunity to raise our views". Minutes of residents' meetings were printed in large print to aid people who had poor eyesight. In addition, staff could read out the minutes to people. The 'Oakland Bulletin' was produced to keep people up to date with what was happening at the home. People and their relatives were asked for their feedback via questionnaires, results of which were positive.

The chief executive told us that staff at this home and the provider's other home worked closely together. Meetings were held at which managers and senior staff shared ideas and views. We asked the chief executive about the vision and values of the service. They told us that they used the standards set out by Skills for Care and these determined the job descriptions for care staff. Referring to these standards, the chief executive told us, "We've had some staffing issues and I don't think staff have always worked to these, so we need to embed our values". We were told of actions that were currently being taken in relation to disciplining some staff. We asked the registered manager about equality and diversity and they told us about a staff member who had difficulties with learning, so were given additional support and help to aid

their understanding. The registered manager talked about their understanding of Duty of Candour and said, "Anything that goes wrong, even if I feel partially responsible, it's about reassuring people and explaining the actions".

Staff felt supported in their roles. One staff member said, "The manager actually listens which is really good. I feel like I'm home. It's one of the nicest places to work. The chief executive is really approachable. The staff are absolutely brilliant and they listen to me and they all work as a team". They added, "[Named registered manager] really cares about the staff and residents and supports me to be the best I can be". We asked the registered manager about the Statement of Purpose and how this was embedded. The registered manager said, "It's on a daily basis, by having very good communication between me and my staff and that we're all heading in the same direction". The chief executive told us, "It starts with recruitment and goes all the way through". The registered manager responded, "We focus on the person and the staff who are going to deliver the best care to people. I treat staff as I treat my residents, in a person-centred way".

Notifications that the provider was required to send to us by law had been completed and sent to the Commission as needed. The Commission's rating of the home, awarded at the last inspection, was on display at the home and on the provider's website.

The provider had achieved the Investors in People Award and staff pay was related to their performance. The chief executive said, "Staff who are extra committed are rewarded" and added that staff were encouraged with their continual professional development and to take on extra responsibility to progress in their career, if they wished to. The registered manager valued the staff and said, "I do appreciate them significantly. I thank them for everything they do". Staff who went the extra mile or who had done something noteworthy at work could be nominated for 'Employee of the Month'. Staff meetings took place and records confirmed this. One staff member said, "We are a strong staff team and communication is very good. Staff meetings are effective, things get sorted. Managers welcome ideas from the staff. I suggested a mini-Olympics and we did it". Another staff member told us, "I love the atmosphere here. We aim to make people happy, for them to have the lives they want. Management put on extra staff to support activities, such as in summer we can help people to go out". An open-door policy was in place and we were told that the owners made visits to the home and speak with staff, obtaining their feedback. Staff were also asked for their views through surveys.

Overall people were happy with the quality of care they received and their views confirmed this. One person said, "I am very happy with the service here and there's absolutely nothing wrong with this place". Another person told us, "I think this is a superb place and I think I'm very lucky to be here". A visitor to the home said, "Everyone in the [geographical] area really does rate this place and would always aim for it. This place is head and shoulders above anywhere around".

As a result of improvements made and the findings at this inspection, the rating under 'Well Led' has improved to 'Good'.