Oakview Estates Limited

Oaklands

Inspection report

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17 August 2018
20 August 2018

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection took place on 14, 15, 17 and 20 August 2018 and was unannounced on the first day, which meant staff did not know we would be visiting. The service is situated on the outskirts of Hexham town centre. Each bedroom has en-suite facilities and there is a range of communal rooms accommodating dining, relaxing and activities. A very large external garden area is available with a separate activity hub situated within it. The service is registered to provide accommodation with nursing for up to fifteen adults with a learning disability, mental health condition or those who may experience autism. At the time of the inspection, fifteen people were living at the service.

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

In 2016 the provider had applied to the Care Quality Commission (CQC) to register a further five beds at the service, making the total 20. This had not been agreed by the CQC as it was not in line with values that underpin the Registering the Right Support guidance. These values include choice, promotion of independence and inclusion. People with learning disabilities and autism using the service can live as ordinary a life as any citizen. Although the service had not been originally set up and designed under the Registering the Right Support guidance, they were continuing to develop their practice to meet this and used other best practice to support them.

At the last inspection, the service was rated Good. At this inspection we found the service remained Good in the caring and effective domains, but the overall rating had deteriorated to Requires Improvement as there were some areas for further development.

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. We were informed during the inspection that the registered manager was working their notice and due to leave in October 2018.

People received their medicines safely, although we have made a recommendation regarding the administration of medicines as we found some people routinely brought to the medicines room to be given their medicines to take with no record of this being agreed. This was not person centred. The registered manager was in the process of addressing this.

There were sufficient staff working at the service, although a number were agency staff and not permanent, which relatives had recognised and commented on as not being ideal. The registered manager was working hard to address this, but recruitment uptake had been slow due to the rural location of the service.

Risk assessments were carried out and promoted positive risk taking which enabled people to live their lives as they chose. We noted that records were not kept of checks made to ensure that staff were shown how to use the mini buses at the service and we have made a recommendation about this. We also asked the registered manager to consider risks in relation to a lift at the service and its isolated location which accessed unstaffed parts of the building.

People told us they felt safe living at the service and relatives confirmed their feelings were the same.

Bedrooms had been individualised in most cases, although we found not all. One bedroom was very sparse in items and in decoration due to the person's needs. However, when questioned, full consideration had not been given as to how this could still be individualised. This was being reviewed by the management team.

People were not always supported to have full choice and control of their lives although staff supported them in the least restrictive way possible; and the procedures in the service supported this practice; the renewal of people's Deprivation of Liberty Safeguarding authorisations had been applied for but delayed due to external factors and was not due to any oversight by the provider.

Although people received choice in things they wanted to do, we found people who could not communicate verbally may not have always been given choice, for example, in the meals they wanted. We also found that a small number of bedrooms may not have been considered in the way they were decorated. In response to our concerns, this was being looked into by the registered manager.

A range of activities were in place for people to participate in within the service and outside in the local community. However, outcomes and aspirations for people were not consistently monitored, encouraged or met. Commissioners for the service confirmed this and we found examples ourselves, including self-medication or holidays wished for.

Staff had received suitable induction and ongoing training. The provider had also recently started to use reflective practice meetings with staff to support this. Staff supervisions were now recorded formally and yearly appraisals had been undertaken. The service conducted sufficient checks to ensure prospective staff were safe to work with vulnerable people. The service had recruitment procedures in place and conducted background checks of all potential staff. References were obtained and criminal background checks were recorded ensuring staff were suitable for their roles.

Where required, people were supported to access health professionals and staff ensured their health and well-being was monitored. People's care needs were effectively communicated through a system of team meetings and handover meetings. Information was communicated in different formats to enable people to understand, including easy read.

People's nutritional needs were met and a variety of food and meals were available.

Staff were supportive in a kind and caring manner. Staff provided people with emotional support. Staff respected people and treated them with dignity, although we found an issue in the garden area which had been addressed by additional fencing being installed. People were encouraged to share their views both inside and outside of the organisation.

There was a complaints policy in place and we saw information displayed on how to make a complaint.

People or other relevant persons were involved in decisions about their care needs and the support they

required to meet those needs. People had access to information about their care. Staff supported people to use various communication systems including FaceTime and Skype.

The service had links with the local community and these were being built upon.

During the inspection, we found several shortfalls in relation to person centred medicines administration, care records, the use of mini buses, the analysis of accidents and incidents, the suitability of the environment and supporting choice and involvement for people who were unable to communicate verbally. We were assured that the registered manager would address these issues.

We have made two recommendations in the report in connection with person centred administration of medicines and mini buses used by staff.

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 consistently safe.

Medicines were managed safely but we found elements lacking a person-centred approach with regards to their administration.

Mini buses were used at the service and we have made a recommendation about their use.

People felt safe and infection control procedures were followed.

Safe recruitment procedures were in place and there were sufficient staff on duty to meet people's needs.

Is the service effective?

Good

The service was effective.

Staff were provided with a suitable induction, training and ongoing supervision and yearly appraisal.

People's dietary needs were met and good quality food and refreshments were provided. People had access to healthcare when required.

Staff had an understanding of the Mental Capacity Act 2005 and of the Deprivation of Liberty Safeguards and they worked within legal guidelines.

Is the service caring?

Good

The service was caring.

People were supported by kind and caring staff.

People's privacy and dignity was maintained. People were able to remain independent.

People were able to express their views through internal meetings and outside forums.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Care and support plans were not always person centred in connection with people's choice. Outcomes were not evidenced as always fully monitored or met.

A complaints policy was in place and easy read information was available to support people to complain if they needed to.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

The registered manager had recently resigned and was due to leave the service in October.

The service was working towards the Registering the Right Support guidance and other best practice models.

During the inspection, we found several shortfalls. These had not always been highlighted by the provider's quality assurance system. We were assured that the registered manager would address these issues.

Oaklands

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection 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 over the 14, 15, 17 and 20 August 2018. It was an unannounced inspection. The inspection was carried out by one inspector, one specialist advisor and an expert by experience. An expert by experience is a person who has experience of this type of service personally or has a specialist interest. The specialist adviser had a background in learning disabilities.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give us key information about the service, what the service does well and improvements they plan to make. We reviewed the completed PIR and notifications we had received. A notification is information about important events which the provider is required to tell us about in law.

During the inspection process, we contacted four local authority teams from various areas who commissioned the service for people, the local authority safeguarding team, local fire authority, a stoma nurse, a learning disability liaison nurse, a STOMP programme lead in the area and the GP practice linked with the service. STOMP is a national NHS England campaign which is aimed at stopping over medication of people with learning disabilities, autism or both. We also contacted Healthwatch. Healthwatch is an independent consumer champion which gathers and represents the views of the public about health and social care services. We contacted two students who had worked at the service on placement. We contacted a member of the local areas positive behavioural support team. Where we received a response, we used information to support the planning and judgements of this inspection.

During this inspection we carried out observations using 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. We also made general observations around the service, including people's bedrooms with permission and all communal areas and unused parts of the service.

We spoke with eight people, three relatives and an advocate involved with the service. We also spoke with seven support staff (including senior support) the activity coordinator, three learning disability nurses, the administrator, the lead maintenance person, two chefs, the deputy manager, the registered manager and a consultant nurse for the organisation. We looked at four people's care records, six staff files and medicine administration records for seven people. We also looked at a range of records relating to the management of the service.

Requires Improvement

Is the service safe?

Our findings

People told us they felt safe and their relatives confirmed this. People told us, "Yes I am safe" and "I feel safe here, the staff are nice." One person confirmed that if they did not feel safe they would tell the manager as they said, "They would deal with it."

One relative said, "Yes I feel [person] is safe. Everything is reported to me and they tell the truth. I know if they are distilling the truth to lessen the impact on me, but they know now I prefer the whole story. Yes, they are safe." The advocate we spoke with told us, "I always ask if people feel safe, have no reason to doubt people are not safe."

There had been some recent safeguarding concerns which had been investigated thoroughly and appropriate actions taken. People were encouraged to report any concerns they had about their (or others) safety and this was discussed in 'service user' meetings to ensure people were not afraid to speak up. Each staff member we asked, confirmed they understood their responsibility to report any concerns they may have regarding any form of abuse and could describe different forms of abuse. Staff had received training in protecting people from harm, which included recent safeguarding training from the local authority. The registered manager knew their responsibility to report issues relating to safeguarding concerns to the relevant authorities.

We reviewed medicines procedures. Several people had medicines taken to them in their bedrooms. However, we saw that a number of people were assisted to the 'treatment' room to receive their medicines and this had not been recorded as having been discussed with the person or by a best interest decision having been made. This procedure was not person centred. We discussed this with the registered manager who said they were considering other alternatives, including a medicines trolley; one person at a time attending the room adjoining the treatment room to receive their medicines in a safe environment and in private, which would also allow people to discuss any medicines concerns they had with staff individually or storage in their bedrooms.

We recommend the provider review medicines administration procedures in line with best practice.

We found people received their medicines when they needed them and from staff who were competent to provide this. Medicines were available for people who lived at the service and were stored securely and disposed of appropriately. The provider was signed up to STOMP. STOMP is a national NHS England campaign which is aimed at stopping over medication of people with learning disabilities, autism or both. We spoke with the STOMP lead in the area who told us that the organisation had signed up to the provider pledge 12 months ago and were "very STOMP aware and keen." We found medicines which had been prescribed for people to support any distressed behaviours were closely monitored and reviewed regularly. The service had an action plan to maintain this process.

Easy read information was available on various medicines which supported people to better understand what they had been prescribed. When we showed one of these documents to a person, they told us they had

seen one of these before and said, "I have seen that before."

Staff told us that two people who lived at the service were capable of being supported to administer at least part of their medicines, particularly with regard to topical medicines. Topical medicines are creams or ointments applied to the skin. The registered manager told us they were working towards enabling this with people who were able and a nurse confirmed this. However, we found no record of how this was being planned and one of the people in question told us staff supported them with all their medicines.

We reviewed five weeks of staffing rotas and staff signing in sheets to confirm staff attendance and staffing levels. The service was staffed by nine staff members during the day with additional staff brought in for outings, visits to families or other events taking place. Although it was busy at times, we found there were enough staff on duty to meet people's needs and people we spoke with confirmed this.

People living at Oaklands all received support from an allocated member of staff throughout the day. This was agreed at the start of every shift and records confirmed this. Any staff shortages were covered using existing staff or agency staff. There had been an element of staff turnover during the previous year. The provider was in the process of recruiting to the unfilled posts but due to the rural location and limited applicants this process had taken longer than expected. The registered manager was aware that it was not ideal to use agency staff, however, the same agency staff were requested where possible. Relatives told us they were concerned about the use of agency staff. One relative said, "It's much better when staff are permanent. They know [person] and [person] knows them. Not the same with stand-ins." Another relative acknowledged that there had been some changes in the permanent staff team and said, "We know staff have left. They are looking, I believe. [Person] gets on well with the usual staff, but don't think it is the same with others."

The nurse consultant showed us how the service had a system in place to learn from any accidents or incidents and to minimise the risk of reoccurrence. We reviewed people's records of accidents and incidents, including daily notes and body maps. One person was found to have had a number of incidents which had been recorded on a body map. This information had not always been signed off by a senior staff member or transferred onto the system to monitor such occurrences. We brought this to the attention of the registered manager and consultant nurse who said they would investigate this omission. We were later informed that three incidents which were consistent with usual presentations and behaviours for the person involved had not been reported correctly and that they had addressed this, including implementing new procedures.

The risks involved in delivering people's care had been assessed to help keep people and staff safe. Risk assessments identified hazards and gave detailed guidance to support staff in minimising the risks. Risk assessments were linked to support plans. Examples of risk assessments included nutrition, mental health support needs and medicines. These records had been regularly reviewed and updated. Risk assessments completed had been summarised onto a document to show the overall risk in each area, however, we found the summary contained some inaccurate information. For example, one person was rated at a level 12 risk but on the summary marked as level four which was much lower. The registered manager was made aware and said they would address this.

General risk assessments had been carried out and regularly reviewed in relation to the home environment. These covered areas such as fire safety, the use of equipment and the management of hazardous substances. This ensured people living at the service, staff and visitors were safeguarded from the risks of any unnecessary hazards. We noted that all staff, including the advocate carried personal alarms to ensure their safety.

We used the lift in the service to check it was in working order and found the area in which it was located was secluded. Although we confirmed no people used this facility, there was potential for people to gain access via the lift to parts of the building unstaffed. Although there are no restrictions placed on people's movements within the service, possible access to unmanned areas posed a potential of risk to people living at the service.

We recommend the provider review access to all areas and risk assess as necessary in line with best practice.

The service had the use of two mini buses which were used, for example, to take people out on trips or visits to relatives. Staff working at the service drove the buses during these trips. We asked what the process was for ensuring staff knew the workings of the mini buses and what checks took place. It was confirmed regular maintenance checks were completed and we were told that staff had been shown how to use the vehicle before taking people out; but this was not recorded. One staff member told us, "When I started, I was not shown how to use the bus; I went down to the shops on my own and I thought that was me finding out then how to use it. There have been no problems though." We saw that driving licence checks were completed, but the provider had not assured themselves that staff were capable of driving a mini bus through any assessment they completed. One of the staff we spoke with had never driven a vehicle of this size (although they were legally able to as per their licence) until they started working at the service.

We recommend the provider reviews their procedures for the use of vehicles at the service to ensure best practice is followed and people's safety is maintained.

The service was well maintained to ensure the safety of the people, staff and visitors that used it. We were shown a range of records confirming that suitable checks were in place to maintain the premises and regular monitoring of safety procedures around the building. For example, fire drills were carried out, maintenance checks on electric, gas and lift equipment were in place and health and safety monitoring was in place.

The service was generally clean and tidy and domestic staff were employed to sustain this. People were encouraged and supported to clean their own bedrooms if they were able. Staff were aware of infection control procedures and used personal protective equipment, such as gloves and aprons as required to prevent the spread of infection.

Recruitment procedures were in place, with checks for example, on references, employment history and applications to the Disclose and Barring Service (DBS) taking place. Registered nurses at the service had their registration checked with the Nursing and Midwifery Council (NMC) to ensure they were suitably qualified to work in the UK. The registered manager later confirmed they were going to check agency nurse registration details as part of their permanent nurse checks.

People were supported with their finances and helped with any purchases required. Records checked confirmed this was done in line with best practice and money checked was in order with accompanying receipts where any spending had incurred. One person told us, "They help me with money as I am not very good."

Good

Is the service effective?

Our findings

Everyone who lived at the service came from out of the local area originally. People's needs had been assessed prior to moving into the service and were regularly reviewed, including during regular multi-disciplinary team meetings (MDT), for example, with relatives, social workers, advocates and the provider's consultant psychiatrist. We spoke with relatives and local authority representatives and they confirmed they were involved with regular review meetings, although we noted that local authority representatives were not always in attendance at the MDT meetings. The advocate we spoke with confirmed their attendance and said, "I attend MDT meetings, definitely."

People's bedrooms were individualised and had been adapted to meet their needs. For example, one person had a sensory device fitted in their bedroom which could be used for stimulation. Staff told us that this was not always the case though. For example, one person's bedroom was very limited in decoration. A staff member told us, "I am not sure why there is no decoration on the walls, [person] likes flowers, so it would be lovely for them." We raised this issue with the registered manager and consultant nurse. Although some mitigation was given to whey the room was bare, it was not fully clear that alternatives had been discussed. The consultant nurse said they would look into this as they felt there was "something we could look at for them." We were later informed by staff that another few bedrooms could be better individualised too to make them "more homely for people".

The garden area was extensive, which people enjoyed walking around and relaxing in. Staff told us the space was not always used to its full potential. One staff member said, "[Person] loves trampolining, what they need is a built in one…you know, the ones in the ground." Another staff member told us, "We had a sensory area, but someone pulled all the flowers out." We viewed the garden area and found that some maintenance work was required, including greenhouse and raised flowerbed areas and the sensory garden area. The registered manager said they were looking at more robust items to go into the garden and were considering other options to make the area more effective for people living at the service.

People told us staff at the service had been effective in supporting them when their anxiety had escalated or they had reacted to their perceived needs not being met. One person explained difficulties they had in the past with negative feelings and how they wanted to fight with people. They explained this happened less frequently and the staff team had helped them to deal with the anger issues they had. Another person told us they were happy living at Oaklands but stated they "get stressed easily". We observed one person became very upset with another person's actions. We observed staff were able to calm the situation very quickly, using methods recorded in the person's care plan.

Oaklands were using the Electronic Health Equality Framework (EHEF). EHEF is a validated best practice approach to demonstrate outcomes of care for the people supported within the service. People's records checked all had these tools in place to support staff in monitoring people's needs. Each person had a hospital passport that would be used if they needed to go into hospital. This included, "Things you must know about me", "Things that are important to me" and "My likes and dislikes." Staff told us these documents would assist hospital staff to provide care in a person-centred way that suited the individual.

People were supported to attend a range of healthcare appointments to meet their individual needs such as GPs and dentists, this included annual health checks. One person had been supported to visit a Stoma nurse. A stoma is an opening on the abdomen that can be connected to either your digestive or urinary system to allow waste (urine or faeces) to be diverted out of your body. We spoke to the stoma nurse who told us, "I cannot really tell you much about the service, but I can tell you that [person] does it all themselves and manages really well." The provider employed their own Speech and Language Therapist (SALT) and occupational therapist and people had been visited by these professionals when necessary. For example, one person had recently had a review by SALT and were in the process of having their dietary care plan updated. The registered manager had been in touch with the local NHS Trust's learning disability liaison nurse and was in the process of sending information to them, in an attempt to make visits and stays in hospital easier for people living at the service.

People had enough good quality food to eat and drink and told us they enjoyed the meals offered. Staff received free meals and ate with people living at the service. The lead inspector asked the expert by experience (one of the inspection team) to participate in lunch and observe staff interactions. They reported the food was "Good and tasty" and "Staff joined in conversations in a relaxed manner." We observed lunch was not rushed and held in a pleasant environment. Food was well prepared and kitchen staff had the information they needed to ensure people received the food they liked and enjoyed that met their dietary needs.

Staff were supported to keep up to date with any changes in people's health by attending handover meetings between teams at the beginning and end of each shift. Any changes that had occurred in people's needs during that period, were shared and discussed.

Relatives told us that the service communicated with them promptly, particularly if any issues arose or if any changes occurred with their family member's needs. One relative said, "They [staff] have always been straight with me up to today. [Person] is so unpredictable and has not got the capability to express themselves, but they have stability here and I am quite happy" and "I have been there [Oaklands] when [person] has not been well. The staff dealt with everything very well. Cannot fault them there." The activity coordinator encouraged people to let their family members know what they had been doing on a regular basis. This was done by sending a personal letter explaining what had been enjoyed and included a photograph and description of the event. Staff told us parents had commented they appreciated and loved to receive the letters. One relative confirmed they had received a letter previously.

Staff demonstrated an understanding of involving people in decisions and asking for their consent before providing care and support. This was documented within care records. Staff knew people well and recognised they could give consent for day to day living decisions, but may need additional support with understanding more complex decisions, such as issues to do with their health. We asked people if they were involved in choices that were made. One person told us they enjoyed participating in activities, but that staff chose them. When we asked further they explained that staff offered three or four choices and they chose which they preferred. One staff member said, "Most people can decide what they want to do, but others need help." Another staff member said, "Sometimes we make best interest decisions for people who cannot make decisions for themselves. We know what people like and use that to help us." Care and support records reflected people's levels of capacity, however, not all of them were clear. We spoke with the registered manager about two people's records and they confirmed these had been updated to confirm where this person lacked capacity to make particular decisions themselves.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible

people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. 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.

DoLS applications had been made appropriately to the relevant local authorities to deprive people of their liberty lawfully, but in some cases there were delays with processing these. The provider was working with the local authority to resolve this as soon as practicable.

Staff continued to receive a suitable induction into the service and a range of training which the provider deemed mandatory. Specialist training had also been provided, for example, positive behaviour support (PBS). PBS is a person-centred approach to people with a learning disability who display or are at risk of displaying distressed or escalated anxieties. A member of the local area's PBS team also confirmed that the provider had signed up to take part in the regional workforce development in PBS and said, "We are expecting six staff in total from Oaklands to complete some formal qualifications in PBS."

The consultant nurse had recently started to undertake reflective practice with all staff at the service. The aim was to discuss any issues or situations arising and look for better ways to address these. Staff explained they had "really enjoyed" the meeting and one said, "I thought it was very beneficial." Although only two meetings had taken place, they were planned to regularly occur. The consultant nurse explained, "Using these meetings is a further approach to ensure that other ways of working are considered, including further use of PBS. We want staff to think of alternative ways to approach their work. Medicines were discussed with nurses and the day before we discussed [person]."

Staff attended supervision meetings regularly and told us they felt well supported in their role. A staff member told us the registered manager was, "supportive and is getting things done that we have asked for." We found that before the registered manager took up their role, supervision was not recorded and only logged as having taken place. Appraisals had been undertaken on a yearly basis.

Good

Is the service caring?

Our findings

People's comments about the staff and the care they provided were as follows; "I like it here, the staff are lovely"; "Staff are nice"; "They care for all of us do the staff"; "I like living here, staff are good. Yes, they are kind to us all" and "I like all the staff and the other people who live here, they are my friends."

A stoma nurse told us, "[Person] comes across as happy and happy to return to the service."

Relatives told us, "I would recommend the service, yes"; "Staff have been very nice, not impersonal"; "Staff are all good that know [person]"; "I think [person] is happy, no reason to think otherwise"; "Yes, there has been changes, but overall I feel that [person] is loved and understood by ones [staff] that know [person]" and "Oaklands rescued [person] from a very dark place" Compliment cards had been received to thank staff for the support and care given to their family members. We also saw an extensive collection of verbal compliments received from people and/or their relatives. We asked one relative about a compliment which was logged against their name and they confirmed it was correct and they had verbally communicated this to one staff member.

People were encouraged to express their views in a number of ways, including in 'service user' meetings held at the service and outside forums. One outside forum including the 'Darlington People's Parliament (DPP) where people confirmed they had visited and taken part and minutes viewed confirmed this too. The DPP is a self advocacy group which meets regularly and discusses local and national issues in connection with people who have a learning impairment or difficulty.

The provider had a family forum for the company which was run by relatives of people who used their services. This enabled families to play a full role in how services were run and the ability to give and receive feedback. We saw pictures of these forums displayed and the families involved.

When we viewed the care and support received by people, we found people or their relatives and/or advocates had been involved in making decisions. One relative told us, "More than involved in decisions. I am involved by telephone or I attend meetings" Another relative stated, "When I visit, we normally make a list of things needed and I agree for them to buy, but they [staff] don't wait if it is something is urgent."

Local authority representatives contacted confirmed either the person or their family or advocate and themselves had been involved in decisions about the care provided and any decisions required. One local authority representative told us, "I go to CPA meetings at least twice a year." Care Programme Approach (CPA) is a package of care and support which is coordinated by a healthcare professional, including for example, social workers.

The service had a large garden area. The space was surrounded by wooden fencing for security and also to maintain people's privacy. We found that one side of the garden was not as protected, however this was acted upon by the time we issued a draft report with additional screening put in place.

One relative told us the service was responsive to their family member's needs and said, "They [staff] look after them [person] and they [staff] dress [person's name] modern and take them shopping." One person told us "I always go to the hairdressers in town to get my hair cut." We saw appointments in diaries for people to attend hairdressers in the local town centre. Some of the people supported at Oaklands could meet their own personal care needs and were encouraged to do so. Where people required assistance, we were told that staff were respectful of people's dignity and privacy. One relative told us, "I have never seen any issues regarding that (dignity and privacy)."

Although most people had family involvement, they also had weekly access to an independent advocacy service. An advocate is someone who represents and acts as the voice for a person, while supporting them to make informed decisions. A picture and the name of the advocate was on notice boards. We spoke with the advocate who told us, "I see everyone in the home just about every week unless they are out. I have my own keys and feel involved with whoever needs support. I get on well with people and they will come and find me if they want to talk. I have raised that it would be nice to have somewhere private to talk to people, somewhere that others cannot disturb you." We brought this to the attention of the registered manager who said that suitable rooms were available. They said they would speak to the advocate to ensure they knew that they could access these areas.

Care records and information held about people was stored securely in a central office to maintain confidentiality and prevent information being used inappropriately.

Records for people documented their interests and what they enjoyed doing. They indicated any specific cultural or religious requirements, and the support required if it was needed.

Requires Improvement

Is the service responsive?

Our findings

People told us that the service responded to their needs. One person said, "I'm very happy here, I like everyone." Another person told us, "Every day is different" and said they always had something to do to keep them occupied. A relative said, "No issues with the level of care provided at Oaklands." A stoma nurse said, "They [person] told us about a sports day they had been to recently and enjoyed."

On the day of the inspection, one person had a water gun which had led to an altercation with another person. Staff we spoke with were not sure where the water gun had come from. We found that in light of people's anxieties and reactions to stressful situations, this activity had not been supported in an appropriate way, including being risk assessed. We discussed this in feedback and the registered manager said they would look into it.

People's needs were supported and reviewed with positive behaviour support (PBS) plans, which detailed how staff could support people in a more person centred and positive way with the aim to increase quality of life and decrease behaviour which may challenge the service. For example, one person had a PBS plan in place which detailed predictors of when the behaviour of the person may deteriorate and included preventative strategies for staff to follow and what support staff should offer after any incident occurred. Care and support plans showed a wide range of person centred information about people, including for example, communication 'passports' with ways to support people with their communication needs. In one person's communication plan it was recorded that they understood only short sentences and staff we spoke with confirmed this.

People's likes and dislikes, their aspirations, and the outcomes they wanted and how they were going to achieve these were also recorded. However, some outcomes had not been actioned and were limited to show how much progress the person had made towards them. One local authority representative from out of the area told us they thought the service had not always been responsive to meeting one person's needs. They told us, "When we have looked through paperwork, we found that [person], when they have been taken out, has eaten on the bus and been brought back to the service rather than staff trying different techniques to encourage eating when out." They continued, "[Person] is going to move to a more local place. There have been two providers who have completed assessments but we want a third and then a best interest decision will be made. We have seen little progression. Staff seem set in their ways. The manager has made some good positive changes, but we are moving [person] now anyway."

One person had recorded they would like to go on holiday, but the date of the outcome had passed and they had not been, nor was there sufficient evidence in recordings to show how staff had supported them to achieve this aim. The registered manager said they were working to ensure that people were supported to achieve their goals and that records were reflective of this.

When we reviewed people's records we found some information had been duplicated in places, was not fully completed, or dates were missing. This included, people's behaviour support plans or day care plans. One person had four communication plans in place. We spoke about our findings in the feedback we gave to

the registered manager. The consultant nurse explained that the provider was in the process of trialling new paperwork in another service and this was likely to influence the record keeping format at Oaklands in the new future.

During observations and review of care records it was not always clear how people who were unable to communicate verbally were provided with an opportunity of choice, for example, in connection with the food they ate. One staff member told us, "We used to use picture cards, but have not done that for a while." We did however, see that picture cards were available. We spoke with the registered manager and consultant nurse about this. They said they would look into this issue.

A local authority team representative told us, "Originally, the staff did not know where the person was from; we raised this five years ago initially and it's only just recently since the new manager started that they have started to produce authentic food for them for example. It was the same with skin care, the staff did not think it was an issue, but they have particular needs, that were not being addressed. They are now though."

Consideration to supporting people with end of life planning and bereavement was in place. No one at the service was currently being supported with end of life care. However, we saw that end of life wishes were recorded in some people's care records. Staff told us people had not always wanted to talk about planning for the end of their lives and this was mainly due to their younger ages. Senior staff had completed end of life training.

Easy read information was available across the service for people to support them to access information easily. This included care and support planning, medicines information, records of meetings for people and information about the local area (maps). We also saw the provider had placed on notice boards, 'sign of the week'. This was to show people and anyone interested what a particular sign meant for a phrase. For example, the sign of the week during the inspection was 'BBQ'. There was a picture of a BBQ and sign language pictures to accompany it to further support people. One staff member told us, "No one [people] uses sign language but they do have their own hand gestures." They went on to describe how one person used their hand in a particular way to show they wanted yoghurt.

The service had taken into account that people whose relatives lived out of area may have needed additional support with physical contact and communication at other times. This included the use of Skype and FaceTime. Both Skype and FaceTime are software applications which allow spoken and visual conversation with someone over the internet. This was seen to be used by a number of people. One relative told us, "[Person] used to ring me before but now they use FaceTime regularly."

One relative confirmed that for a special birthday their family member was brought by staff to a cottage to celebrate "in style" with other family members, including aunts and uncles. Staff returned to collect the person after the event. The same family member confirmed that their relative had visited a variety of places organised by the staff team. During the inspection one person was taken on a three-hour drive to visit their parent. We spoke with them later and they confirmed that it had been, "Very good, I enjoyed it."

Each person had an activity timetable that provided them with a choice of a variety of activities both within the home and the local community. We observed that during our visit activity timetables differed to activities taking place. We asked the reason for this and were advised that as it was the school holidays and several activities such as horse riding and swimming were not available or it was felt that those venues would be too busy and noisy for some people. Staff assured us that when this was the case it was always explained to the person and alternatives offered. We saw evidence this was the case. One person confirmed "There are plenty of activities to do." One relative singled out the activity coordinator for additional praise

for the work they did. We saw pictures of visits, including for example, a trip to Beamish [an outdoor museum]. Other activities included, arts and crafts, going to the pub, trampoline sessions and attending a local outdoor activity centre.

A 'read and write' group was facilitated for people to attend if they wanted to. We confirmed this with one person who attended. They said, "Yes, I go there."

People were encouraged to support their life skills with cooking or laundry sessions held within an adjoining building called the pyramid, where additional cooking and washing facilities were available. One person confirmed they enjoyed using the kitchen and baking cakes.

We were confident that people had the opportunities to complain or raise concerns if they needed to and would if they had to. There was an easy read complaints policy on the display and people had access to this. Complaints were discussed as part of 'service user' meetings held. One person told us, "I know how to complain. I do if I need to." There had been no complaints recorded over the inspection period. One person told us that if they reported any concerns to the manager they would feel safe doing so. We read minutes of recent 'Service user meetings'. These showed the majority of people living at the service had been fully involved, but we saw little input from people who were unable to verbally communicate. The provider told us they were working to improve this to gain input from all people living at the service.

Requires Improvement

Is the service well-led?

Our findings

In 2016 the provider had applied to the Care Quality Commission (CQC) to register a further five beds at the service, making the total 20. This had not been agreed by the CQC as it was not in line with Registering the Right Support guidance. Although the service had not been originally set up and designed under the Registering the Right Support guidance, they continued to develop their practice in order to meet this guidance and used other best practice to support them.

Oaklands had a registered manager. We were informed during the inspection that the registered manager was working their notice and due to leave in mid-October.

People's comments about the registered manager included, "Nice person" and "Yes, I like her." Relatives comments regarding the registered manager included; "Found her to be pleasant" and "Good at listening and acting on issues with [person]." One relative told us, "Overall I am pretty pleased [with the service provided]."

At the time of the inspection people and their relatives had not been made aware of the registered managers resignation, but we were told this was being carefully planned as to not distress anyone.

Staff stated that the registered manager was a, "Good manager" and "Put a lot of changes in which I can understand why." The majority of staff we spoke with were positive about the registered manager, although two staff felt they had made unnecessary changes and were not complimentary about their attitude. We were able to confirm that any changes which had been made were necessary and in order to keep the service in line with current legislation and best practice. Staff told us they were concerned about the registered manager leaving and thought there would be a period of unsettlement because of this.

A local authority team representative told us, "The manager is good. She is spot on with any concerns and has taken on board any issues I have raised." Another local authority representative told us they were concerned that the registered manager was leaving and said, "This will unsettle staff and likely some of the service users."

The registered manager had been at the service a number of months. Much of their time had been taken up initially with the safeguarding concerns raised earlier in the year. We found that once the safeguarding concerns had been highlighted, the provider deployed a team to support the service and undertake an initial investigation which was made available to relevant professionals involved.

During the inspection, we found several shortfalls in relation to person centred medicines administration, care records, the use of mini buses, the analysis of accidents and incidents, the suitability of the environment and supporting choice and involvement for people who were unable to communicate verbally. We were assured that the registered manager was working to address these issues.

There was a range of audits and checks in place, including in connection with medicines and health and

safety procedures at the service. The provider's representatives visited the service to monitor compliance and check the quality of the service being provided.

People had received surveys to complete and safeguarding questionnaires to gain their views. We saw that comments made that needed action had been addressed. For example, one person had commented that they wanted to help staff more at meal times clearing up and wiping tables. We observed elements of this taking place with people after meals times. Another person had commented on the food types available. We spoke with kitchen staff about this and they said they had changed menus and tried a range of foods to satisfy everyone's dietary needs. The provider had also placed a large notice in reception areas which detailed all the responses they had actioned in relation to comments made in the surveys.

People were supported by a staff team, some of whom had worked over 10 years or more at the service and who were happy to be working there. People were actively supported to access their local community facilities such as local shops, cafes, leisure centres and supermarkets. Staff morale appeared good, although staff told us it had dipped lately because of the safeguarding issues which had been raised and investigated. Staff said they felt confident in their roles. All staff we spoke with told us they would recommend the service as a place to receive care and support. Awards and incentives were available to the staff team, including, 'Danshell's (the provider) Shining Star Awards, which were nominations from staff about other staff who had gone the extra mile. The provider also had a range of staff discounts in place, including childcare vouchers.

Staff said they felt supported by the registered manager. Regular staff meetings were held which offered staff an opportunity to make suggestions and provide feedback. These included daily 'flash' meetings with heads of departments and general staff meetings. One staff member told us they had felt particularly well supported by the providers 'on call' system. They told us, "There had been an incident which had left me shaken, but I have to say that they [on call] were straight out to support me. When they were contacted they said, 'right am on my way' and came straight out." We saw the provider had secured the services of a confidential and private counselling service for staff to use if they felt pressured or needed someone to talk with. One staff member told us, "It's a good service to have but I personally have never used it. I think it is advertised in the newsletters we get."

As the service was embedding the principles of 'Registering the Right Support' it had expanded its network to include services outside of the provider organisation. The service worked with other organisations to ensure co-ordinated care. The registered manager had worked in partnership with other agencies such as the learning disability liaison team and the local GP surgery to ensure the best outcomes for people. For example, regular contact was made with the GP surgery and this was confirmed.

The consultant nurse and the registered manager had made links with local universities and had offered training to local police, to raise awareness of learning disabilities and promote best practice. Established contact had been made with training providers and the service had received a number of students on placement.

The provider was meeting the conditions of their registration and submitted statutory notifications in a timely manner. A notification is information about important events which the service is required to send to the Commission by law. The most recent rating was displayed within the service and on the providers website.