Care Quality Commission

Surrey and Borders Partnership NHS Foundation Trust

Oakwood

Inspection report

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Date of inspection visit:
24 March 2023
27 March 2023
04 April 2023
24 April 2023

Date of publication:
27 July 2023

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Oakwood is a residential care home providing personal and nursing care to up to 7 people. The service provides support to people with a learning disability and autism in a one-story purpose built home. At the time of our inspection there were 7 people using the service.

People's experience of using this service and what we found
We expect health and social care providers to guarantee people with a learning disability and autistic people respect, equality, dignity, choices and independence and good access to local communities that most people take for granted. 'Right support, right care, right culture' is the guidance CQC follows to make assessments and judgements about services supporting people with a learning disability and autistic people and providers must have regard to it.

Right Support:
People were not always supported to identify and work towards achieving their goals and aspirations. Staff did not always support people in a person-centred way and people were not always offered the opportunity to go out or to do the things they enjoyed. The service had a clinical rather than a homely atmosphere. People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice.

Consistent guidance in how to support people during times of distress was not always available to staff. This meant there were occasions where staff used restraint techniques which had not been recommended. Post-incident reviews were not routinely held where people had experienced being restrained. Medicines were not always managed safely and people's health in relation to their medicines was not routinely monitored as required.

Staff were receiving additional safeguarding training to ensure they were aware of their responsibilities to people. There was good standard of hygiene and staff were seen to be following infection prevention and control guidance.

Right Care:
Robust assessments were not always completed prior to people moving into Oakwood to ensure their needs could be met and were compatible with others. People's health needs were not always monitored which had led to delays in health referrals being made for some people. People were not supported to develop their independence and were not routinely involved in care planning and decisions such as planning what they wished to do and what/where they would like to eat.

In some areas we found people had been supported well with their healthcare needs and professionals told us this had led to an improvement in their health.

Right Culture:
Staff did not see people as their equal and outdated language such as referring to people as 'patients' was frequently used. Not all staff knew people well which meant they were unable to respond to people's needs and communication appropriately. Staff training was not effectively monitored and not all staff were able to demonstrate training and understanding of supporting people with a learning disability and autism. Managers and staff were not aware of the 'Right support, right care, right culture' guidance and how this should influence the support people received.

There was a lack of management oversight which had led to concerns not being identified and acted upon. Some staff told us there had been a negative culture at the service for some time, with the service being run to meet the needs of some staff members rather than the needs of the people living at Oakwood. Audits and reviews were not effective in identifying shortfalls in the care and support people received. There was a lack of forward planning and the management team had not demonstrated a drive to meet high standards and ensure continuous development.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection
The last rating for this service was good (published 10 January 2020).

Why we inspected
The inspection was prompted in part due to concerns received from the provider, relatives and professionals about people being at risk of abuse. A decision was made for us to inspect and examine those risks. The provider informed us they had informed relevant authorities about the concerns. A number of regular staff were not working at the service at the time of our inspection to ensure investigations could be fully and fairly completed.

We found no evidence that people were at risk of abuse at the time of our inspection. However, breaches of regulations in other areas were identified.

The overall rating for the service has changed from good to inadequate based on the findings of this inspection. You can see what action we have asked the provider to take at the end of this full report.

Enforcement
We have identified breaches in relation to the way risks to people's safety were managed, medicines management, person-centred care, consent to care, management oversight and governance at this inspection. We issued warning notices against the provider in relation to these concerns.

Follow up
We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe and there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement

procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not safe. Details are in our safe findings below.	**Inadequate**
Is the service effective? The service was not effective. Details are in our effective findings below.	**Inadequate**
Is the service caring? The service was not caring. Details are in our caring findings below.	**Inadequate**
Is the service responsive? The service was not responsive. Details are in our responsive findings below.	**Inadequate**
Is the service well-led? The service was not well-led. Details are in our well-led findings below.	**Inadequate**

Care Quality Commission

Oakwood

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Health and Social Care Act 2008.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection was carried out by 2 inspectors, 1 medicines inspector and an Expert by Experience who spoke with relatives via telephone. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
Oakwood is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Oakwood is a care home with nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was a registered manager in post although they were not present during our inspection.

Notice of inspection
The first day of our inspection was unannounced. We gave the service a short notice period of our subsequent days of inspection to enable people living at Oakwood to be made aware of our visit. We visited Oakwood on 24 and 27 March and 4 April 2023. We visited the providers head office on 24 April 2023.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We observed people and their interaction with staff and each other throughout the inspection visits. We spoke with 5 relatives and 3 health and social care professionals to gain their views. We also spoke with 14 members of staff including 10 care staff, deputy manager, interim manager, head of specialist care and the director and associate director of services for people with learning disabilities. We viewed a range of records held within the service, this included 5 care plans and multiple medicines records. We looked at 4 staff files in relation to recruitment. A variety of records relating to the management and oversight of the service, including staff training records, risk assessments, policies and procedures were reviewed. After the inspection we continued to receive information relating to quality assurance audits, policies and procedures. We sought clarification on staffing, staff training and competencies.

Inadequate

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At our last inspection we rated this key question good. At this inspection the rating has changed to inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong
● Guidance for the use of appropriate and safe restraint was either missing from people's care records, or not always followed by staff. One person's records showed staff had used restraint to prevent the person harming themselves and others. However, information on how to use restraint was inconsistent, with limited guidance available regarding how to monitor the person's well-being, how to communicate with the person during this time or how to move on from the incident. Guidance recommended staff only restrain the person's upper body although records showed staff had held the persons arms and legs. This meant staff may cause additional distress or harm to the person by using inappropriate restraint techniques.
● Staff involved in incidents of restrictive practice were not routinely involved in post-incident reviews. This meant they were not supported to consider how to minimise the risk of restraint needing to be used in similar circumstances. Staff informed us reviews did not take place following incidents as a matter of course. Incident records did not evidence staff had been involved in this process and risk assessments were not routinely reviewed following incidents of restraint.
● Staff and managers did not always demonstrate understanding of what constituted restraint. One staff member told us, "We sometimes hold them to stop them hurting themselves, we do not restrain them." When describing an incident to a manager where four staff members were holding a person's limbs, they told us they did not feel this was restraint.
● People were not always fully involved or supported when changes were made within their home and risks were not monitored. On the first day of our inspection we were told one-person preferred doors to be locked as this gave them a sense of security. On our third day of inspection the management team told us they had made the decision that a door would be unlocked to give others more freedom and space. No risk assessment had been completed regarding this change and the person had not been consulted. When the person discovered the door to be open, they became highly anxious and upset which also caused distress to others.
● Risk management plans in relation to keeping people safe were not always clear. People's records stated where they needed support such as 1-1 staffing or 3-1 staffing when out. However, there was no detail regarding how this should be provided to minimise the impact on people and ensure risks were controlled as far as possible.
● Accidents and incidents were not routinely monitored. No analysis was completed of accidents and incidents in order to identify potential themes and trends. In addition to accident and incident forms, monitoring charts were used to record people's anxiety. These had not been consistently completed to assist in identifying potential triggers to people's moods or ways in which staff had supported people to be calm.

The failure to ensure robust safety and risk management systems was a breach of Regulation 12 of The

Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely
● Robust medicines practices were not always followed. During the inspection we saw inconsistencies in medicines stock counting. Inconsistent records meant the provider and registered manager could not be assured people were always getting their medicines as prescribed.
● 'When required' (PRN) medicine protocols were not in place for everyone's prescribed medicines. These documents help staff to know when and how to safely administer a medicine. Where they were in place, they weren't always accurate, and staff did not always follow the recommendations on them. When PRN medicine had been administered, the reason for administration and outcome was not recorded consistently.
● Protocols to support the use of emergency medicines for people with epilepsy were not always clear. Staff did not always follow the instructions on these. Copies of these documents were not included with rescue medicines when people went out of the home with staff.
● Medicines risk assessments were not in place. There was no process or record of regular monitoring of physical health for people prescribed a high dose anti-psychotic therapy (where medicines are over the recommended daily limits of anti-psychotics and could lead to increased side effects as well as other physical health difficulties). In addition, people prescribed paraffin-based skin products had no fire risk assessments in place.

The failure to ensure robust medicines management systems were in place was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment
● There were enough staff to support people. However, there was no planned approach to ensure the skill, experience and competency of staff was considered in the deployment of the staff team. Staff expressed concern regarding the skills mix and experience of staff working at the service. Due to the on-going safeguarding concerns at the time of our inspection a large proportion of the regular staff team were not supporting people at Oakwood. In addition, a number of staff had been employed at Oakwood for a relatively short time. Whilst all shifts had been covered by increasing the use of bank staff, this meant not all staff working in the service knew people well. This caused people significant anxiety. One staff member told us, "This is why they [people] are upset and shouting all the time, because they don't know the staff and staff don't do things how they like it done. It's hard for them and that makes it hard for us."
● A relative told us they were concerned staff working at Oakwood at the time of our inspection did not have the skills and knowledge of their loved ones needed to keep them safe. One relative told us, "[Person] tells us the staff don't know his routines and he doesn't want to talk to them. Things are worse than ever at the moment." A second relative told us, "There are a lot of new staff who aren't investing the time in getting to know him. There has been an increase in incidents and we're back to staff being in the room and in babysitting mode."

The failure to ensure sufficient numbers of suitably qualified, competent, skilled and experienced staff were deployed to support people safely was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Systems were in place to ensure staff were recruited safely and records confirmed a range of checks had been requested and obtained prior to new staff commencing work in the service. This included references and disclosure and barring checks (DBS). DBS checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make

safer recruitment decisions.

Systems and processes to safeguard people from the risk of abuse
● Not all staff were able to demonstrate understanding of the safeguarding process. The majority of staff had completed safeguarding training and understood their responsibilities. However, not all staff spoken to were able to describe the types of abuse people may experience, signs of concern or reporting procedures. This meant there was a risk concerns would not be identified and reported appropriately. The provider assured us all staff safeguarding training would be reviewed.
● Where safeguarding or whistle-blowing concerns were reported, the provider took prompt action to address this. Concerns were shared with relevant statutory bodies such as the police and/or the local authority safeguarding team as required.
● The provider worked alongside other statutory agencies to investigate safeguarding concerns. This included providing additional information as requested and accommodating visits from safeguarding advisors.

Preventing and controlling infection
● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was supporting people living at the service to minimise the spread of infection.
● We were assured that the provider was admitting people safely to the service.
● We were assured that the provider was using PPE effectively and safely.
● We were assured that the provider was responding effectively to risks and signs of infection.
● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.
● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
● We were assured that the provider's infection prevention and control policy was up to date.
● People were able to receive visitors to their home in line with government guidance.

Inadequate

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At our last inspection we rated this key question good. At this inspection the rating has changed to inadequate. This meant there were widespread and significant shortfalls in people's care, support and outcomes.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

- People's needs were not always robustly assessed prior to them moving into the service. Both managers and staff told us they did not feel Oakwood was the right home for one person living there due to the physical environment and the lack of opportunities to develop skills. Managers told us the person had moved to the service as they needed to move from their previous accommodation at short notice. The provider was unable to demonstrate a thorough assessment had been completed to determine how the person's needs could be met. We observed the person experienced frequent episodes of high anxiety and distress which staff found difficult to support them with.
- The needs of others living at Oakwood were not always considered prior to others moving in. For example, one person's anxiety was known to be triggered by loud noises and shouting. Despite this, a person who was known to demonstrate their own anxiety and distress by shouting had moved into the service. This had caused distress to others and led to them spending more time in their own bedroom rather than in the lounge area.
- Best practice guidance was not always followed or understood. Staff and managers told us they were unaware of the content or scope of the Right Support, Right Care, Right Culture guidance. They told us that although they had heard the term, they had not completed any training or received support in ensuring the guidance was implemented. During our inspection we found the principles of Right Support, Right Care, Right Culture were not followed and people were not empowered to live as ordinary life as possible in line with this guidance.

The failure to ensure people's needs were thoroughly assessed and that best practice guidance was always followed was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff support: induction, training, skills and experience

- Staff did not always have the training, skills and experience required for their roles. Three of the 8 care staff spoken to told us they had not completed training in supporting people with a learning disability and autism. One staff member told us, "I learnt on the job by following colleagues, there was no training for this." The lack of understanding of the needs and rights of the people staff were supporting is evidenced by concerns regarding people's safety, quality of life and the lack of person-centred support highlighted throughout this report.
- Staff had not always received training in restraint techniques that had been recommended as safe to use with people. Two people's records contained guidance that as a last resort staff should use a specific type of

restraint, but staff had not been offered training in this for a number of years. Staff we spoke with confirmed they had not received training in this form of restraint.
● Staff did not receive regular or effective supervision to support and guide them in their roles. A supervision matrix for the service was maintained which stated over 75% of staff had received supervision in line with the providers policy. We reviewed 6 staff supervision files where the matrix showed they had received supervision. Notes showed 3 staff had received only one supervision in over 15 months. Supervision records varied greatly in their detail with some records only stating there were no safeguarding concerns raised and training had 'been discussed'.
● Staff did not receive a detailed induction in relation to people's needs. An induction file contained a one-page profile of six of the seven people living at Oakwood. This information was out of date and contained very little information to support staff knowledge. This was of particular concern given the complex nature of the needs of those living at Oakwood.

The failure to provide effective training, induction and supervision to all staff was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to eat and drink enough to maintain a balanced diet
● People did not always have choices in relation to their meals and drinks. We asked staff how people made choices regarding their foods on a daily basis. They told us people were offered a choice of breakfast from cereals and toast. Other meals were made in line with the menu plan. No choices were observed to be offered to people living in the shared area of the home.
● The menu plan was not reviewed regularly with people. A 4-week rolling menu was followed where 4 people had chosen one evening meal for everyone during the week. This menu plan had been in place for over 15 months with only one review taking place 12 months prior to the inspection. There was no evidence that people had been consulted regarding if they wished to have any changes made to the menu.
● People's support plans were not followed to enable them to eat in a calm and appropriate environment. One person's care plan stated they should be supported to eat in the dining room to avoid isolation. During the inspection the person was supported to eat on their own. One relative told us their loved one was encouraged to eat in their bedroom rather than sat in the dining room which they believed was de-skilling them.
● People were not supported to maintain a healthy weight. A number of people had been identified as needing to lose weight. Although staff told us they were aware of this we saw the type of food and portion sizes were not effectively monitored to support people with this goal.

The failure to ensure people were supported to maintain a healthy weight and were provided choices in relation to their food was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Some people who lived in their own flats were supported to make daily choices regarding their meals and went shopping for ingredients. This enabled them to monitor their own food intake and have control over what and when they ate.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● People did not always have Health action plans in place in order to ensure their healthcare needs were monitored. Where these were in place, they were not regularly reviewed to ensure people's needs had not changed. Appointment calendars were not up to date to ensure people's health could be easily tracked.
● People's healthcare was not routinely monitored. One person's records showed they had been prescribed

glasses. There was no evidence of this being explored with the person or of an optician's appointment being made. Another person's records showed they had been referred to the chiropodist in April 2022 and had a dental appointment booked for June 2022. There was no evidence in health action plans or daily notes showing the person had seen a dentist or their chiropody referral chased.
● Changes in people's health care needs had not always been identified and acted upon. Families and professionals informed us of occasions where health care concerns had been reported to the home. They gave examples of being informed of referrals being made although they subsequently found this had not been completed. We received assurances that action had now been taken to address these concerns.

The failure to ensure people's health care needs were robustly assessed and monitored was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People had been supported to attend annual health care checks and medicines reviews with their GP's. In addition, some people had regular contact with the community learning disability team responsible for reviewing their health and support needs.

Ensuring consent to care and treatment in line with law and guidance
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 MCA requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA , whether appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met.

● People's legal rights were not always protected as the principles of the MCA were not followed. Capacity assessments were not always completed as required. No capacity assessments had been completed for two people despite DoLS applications being submitted which highlighted they lacked capacity to consent to restrictions including locked doors, constant supervision and potential restraint.
● Where capacity assessments had been completed, best interest decisions were not always recorded. This meant there was no evidence to demonstrate the least restrictive options were used and any preferences shown by the person considered.
● Conditions within DoLS authorisations were not always met. One person's DoLS authorisation stated their capacity and best interests in relation to their finances and use of PRN (where required) medicines should be assessed. Whilst there were general capacity assessments in relation to medicines and financial management these were not as specific as stated within the DoLS authorisation and no best interest decisions were recorded. Conditions in relation to submission dates for the reapplication of DoLS authorisations had not been met with the applications of 4 people having been submitted late.
● Not all staff were aware of their responsibilities under the MCA. Whilst some staff had knowledge of the MCA, we spoke to others who had not heard of this legislation and were unaware of its purpose. One senior staff member responsible for completing capacity assessments was unaware best interest decisions needed to be completed as they believed this was done within reviews. We checked to see if these discussions had taken place within reviews for the person they highlighted and found no evidence that best interest decisions had been discussed since 2017.

The failure to ensure the principles of the Mental Capacity Act 2005 were followed was a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Adapting service, design, decoration to meet people's needs

● The environment at Oakwood was not homely or stimulating. There was a clinical feel to people's home with few soft furnishings or sensory items. Consideration had not been given to how to make the environment more cosy whilst considering people's needs and anxieties.

● The design of the building did not support people's sensory and emotional needs. A number of people living at Oakwood were sensitive to noise. Ceilings in the main lounge/dining area were high, there were no carpets and there were glass windows around the central courtyard area. This created an echo which reverberated when people were shouting, making this sound louder. The windows in the central courtyard meant people could see around the home from one place. Staff told us this could be a concern when someone was distressed in one area of the home as it could increase anxieties in people living in a different area who were able to view the incident.

● Senior managers told us they had recognised the concerns with the environment. They told us they were working with people and alongside other services to gain views on making safe changes to the environment.

● Relatives told us family members had items of their own choosing in their rooms. One relative said, "Their room is actually really nice. We have taken things in and it looks cosy."

● Oakwood was a single storey building with good access. A central garden area had been developed with sensory items. Consideration had been given to the design of some furniture which had been recently purchased to ensure people's safety.

Inadequate

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At our last inspection we rated this key question good. At this inspection the rating has changed to inadequate. This meant people were not treated with compassion and there were breaches of dignity; staff caring attitudes had significant shortfalls.

Ensuring people are well treated and supported; respecting equality and diversity; Respecting and promoting people's privacy, dignity and independence

- Relatives provided mixed feedback regarding the caring nature of staff. One relative told us, "Some of them are okay but it's just a job to them, there's no team or accountability. I've seen some of them just sitting there with their hoods up and not speaking to the residents at all." Another relative told us, "They go above and beyond for my [loved one]."
- Despite observing some individual caring interactions, we found staff did not always see people as their equal. There was a lack of warmth from some staff members towards people. We observed staff holding private conversations with each other whilst people were clearly requesting support from them. The way in which some staff moved around between rooms watching people, created a feeling of them patrolling the areas rather than supporting people. One relative told us, "It still feels like an institution. Staff still wear uniforms. It doesn't feel like a home."
- The way in which staff spoke about people was not always respectful. Staff used terminology which reflected they saw Oakwood as a clinical setting rather than people's homes. For example, staff referred to people as 'patients' and referred to people going on 'home leave' when visiting their families. Senior managers acknowledged they had identified this concern and were aware the culture needed to become more personalised.
- People were not supported to develop their independence. One relative told us, "They don't let [loved one] in the kitchen. They're over cautious. It's easier for them to do nothing[with the person]." We did not see people involved in the running of their home or being supported with daily living skills. On the third day of our inspection, managers told us they had identified this concern and had asked staff to get people more involved in making their own drinks.
- Staff did not always show respect for people's personal belongings. One relative told us of numerous items which had gone missing and of a bag new clothes being found unused on top of a cupboard several months after being purchased. When this had been raised this with staff, relatives felt their concerns were dismissed and not taken seriously. The relatives were concerned this meant the person had not had a choice of clothes which fitted them correctly during this time.
- People were not always supported to practice their faith. Going to church each week was important to one person. However, their daily records stated they had only been supported to attend church twice over an 11-week period.

The failure to ensure people were treated with respect and their independence promoted was a breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People's privacy was respected. Staff supported people with their personal care in a private area. We observed staff ask permission to enter people's rooms or flats.

Supporting people to express their views and be involved in making decisions about their care

● Relatives told us they did not always feel consulted or listened to. Two relatives told us they had been requesting a review of their loved one's support for some time to enable planning and development. The registered manager had not responded to these requests or had informed families that other professionals were unavailable to meet.

● People were not consistently involved in making decisions about their care. Support plans and records did not always reflect how people had been consulted regarding decisions or in the support planning process. One person's support plan stated they were not involved in their support plan due to their learning disability. However, the person was able to express their preferences, what they liked to do and when. Records did not record details regarding what people had done to enable staff to develop a fuller picture of their likes and dislikes such as what music or films they liked, what they had gained enjoyment from or had found difficult.

● People's skills and past achievements were not taken into account when planning people's care. Staff and relatives told us of people's achievements both at Oakwood and at other places they had lived. These skills such as going shopping, cooking and going out to different places had not been continued or developed.

The failure to ensure people and their relatives were involved in decisions regarding their support was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● For some people who were able to communicate their wishes to staff verbally we found staff responded more positively. For example, one person was supported to go shopping most days to choose their food and were supported to prepare this with staff.

Inadequate

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At our last inspection we rated this key question good. At this inspection the rating has changed to inadequate. This meant services were not planned or delivered in ways that met people's needs.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

● Relatives told us they felt there was a lack of things for their loved ones to do. One relative said, "In terms of activities nothing much goes on. There's and art room but it's never used." A second relative told us, "They don't listen to him and staff don't know what he wants to do. There's just nothing offered." Professionals we spoke to told us, "From the social aspect that's where it has failed; The not going out and the social care."

● People did not always have plans in place for how they wished to structure their time. We observed this meant people spent long periods of time sitting in their rooms, in communal areas or walking around the building. Where people's support plans did contain 'activity' plans, these were not always meaningful and were not always followed by staff. One person's week consisted of taking daily showers, meals, discussing the day, relaxation, games and walks or drives.

● People did not always have the opportunity to do things they enjoyed. People's care plans contained information about places they like to go and things they had developed interests in. However, daily records showed some people did not have the opportunity to go out on a regular basis. Where people were supported to go out this was often for a drive rather than to do anything or to go anywhere specific.

● One person's records highlighted their days needed to be full of things to do in order for them to maintain both good physical and mental health. Daily records did not evidence staff supported the person with the level of opportunity recommended and relatives confirmed this was the case. Staff told us another person would only go out with certain staff members, some of whom had left and some who were not currently at work. There had been no forward planning to expand the number of staff the person felt comfortable going out with and no structured plans regarding how this would be developed going forward. This meant the person had not been out for a number of months.

● People's sensory needs and enjoyment were not always considered. The sensory room had not been available to people for some time due to the equipment being broken. This had been recently mended prior to our inspection although records did not show people were supported to use this facility. One professional told us, "We were told about the sensory facilities when we looked round but these have rarely been in working order or used. It's a real shame as this is such a plus point for [person]."

The lack of opportunities to go out and do things people enjoyed was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

● People's needs and preferences were not always known to staff. Staff we spoke with and observed were

not always able to describe people's needs and how they liked things to be done. Staff who had worked at Oakwood for some time told us this was having a negative impact on people's well-being. One staff member said, "Some staff don't know (how a person liked their shower) or don't bother to read care plans or ask. They just go in there, give him a quick shower and then wonder why his behaviour escalates." There was a lack of planning regarding how staff should share their knowledge to minimise the impact of change.
● People's individual preferences were not always responded to. For example, having a bath in the evening was important to one person to aid their relaxation and for sensory enjoyment. However, due to the needs of others, they were unable to access the area of their home where the bath was situated. Professionals supporting the person told us this had taken away something which had previously been a significant part of the person's day.
● People were not supported to develop and achieve goals. One person's goals showed they were interested in attending college and swimming. Staff told us work towards these goals had not started despite these having been in place since 2022. Another person's goal had been to go on holiday in 2022. Discussions and reviews showed this was extremely important to the person. In August 2022 notes stated the person would be going on holiday the following month. However, senior managers told us this had not happened as staff were not available to support the trip. No plans were in place to support the person with this going forward. We noted for other people no goals had been discussed or set.

The lack of personalised support and opportunities for people was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We saw some staff and people getting along well together. When staff were supporting people in a caring and inclusive manner, we noted a more positive and relaxed atmosphere in the home.

Meeting people's communication needs
Since 2016 all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard. The Accessible Information Standard tells organisations what they have to do to help ensure people with a disability or sensory loss, and in some circumstances, their carers, get information in a way they can understand it. It also says that people should get the support they need in relation to communication.
● People's communication plans did not always take account of people's sensory needs. It was felt one person may benefit from assistive technology due to sensory loss. However, this had not been explored further and referrals to assess the best way to proceed had not been made. Communication plans did not always consider how people who were sensitive to loud noises should be supported to minimise the impact of living in what could be a noisy environment.
● Not all staff knew how to communicate effectively when people were asking for support or showing signs of anxiety. We observed that whilst some staff gave people acknowledgement, they did not proactively try to find out what the person wanted or show interest. This resulted in senior managers regularly needing to intervene to provide support and reassurance.

The failure to ensure people's communication needs were known to staff and acted upon was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Improving care quality in response to complaints or concerns
● Relative told us that although they had raised concerns with the registered manager and senior staff these had not been treated as complaints and were not always responded to. One relative told us, "Communication has been dreadful. You raise something and it just gets ignored. It erodes trust." Relatives and professionals told us since senior managers had been present at the service this was starting to

improve.
● The service had recorded one complaint in the past year. This was not directly related to people's care. Senior managers told us they had been made aware that some relatives had concerns regarding the support their loved ones were receiving. They told us they had implemented a more robust communication strategy to enable families to express their views and would ensure these were acted upon. Relatives and professionals told us they were now beginning to receive responses to their concerns.
● The provider had a complaints procedure in place which was widely available online. This set out details of how to make a complaint, how these would be investigated and timescales for receiving a response.

Inadequate

Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At our last inspection we rated this key question good. At this inspection the rating has changed to inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- Relatives told us they did not always feel their loved ones were put at the centre of their support. One relative told us, "It's run for the staff and the residents have to make compromises on everything. It just doesn't feel like their [loved ones] home."
- The management team had failed to identify and address the closed culture within the staff team. Staff members told us there had been a culture of a few staff determining how the service was run. One staff member described Oakwood being known by other services to be a difficult place to work due to the negative culture. Another staff member told us, "There were a few staff who could not be challenged here and have made life uncomfortable for the manager, the residents and the staff. If this had been addressed long ago like it should have been we would be in a better place now."
- The management systems in place did not promote a culture where people were supported in a personalised way to have a good quality of life. Staff worked in a task focussed way where set routines were followed rather than respecting people's Individuality. Records of team meetings minutes lacked detail and contained derogatory language about people such as describing someone as being 'manageable for the past few days'.
- There was a lack of management focus in supporting people to develop. Systems were not in place to record people's goals, provide varied opportunities and monitor progress. Senior managers spoken with during the inspection acknowledged this and told us they were looking to develop systems and staff practice.
- Both managers and staff referred to the service being a health care or clinical setting. This demonstrated a lack of vision regarding the aims of Oakwood being people's home where they felt settled, empowered and cared for. One professional told us, "It's a very clinical model and staff follow this." The leadership team had not identified or addressed this concern to improve the culture within Oakwood.

The failure to ensure the culture was person centred and achieved good outcomes for people was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

- Relatives told us they had difficulties in communicating with the registered manager. One relative told us, "[They] were always too busy, nothing came back." A second relative said, "[Registered manager] was always pleasant but always gave the impression of being too busy. They were always in their office and

usually had the door closed."
● Quality assurance processes were not effective in identifying shortfalls in the service people received. Monthly audits were completed by different managers on a rotational basis. The last audit completed was dated the end of February 2023. This described Oakwood as an excellent service. None of the issues found during our inspection had been identified in this audit.
● Where issues were identified, these were not always actioned or carried forward. The quality audit completed in December 2022 had identified some concerns. These included the need to evidence debriefing sessions were held with staff following incidents, to explore ways of minimising one person's distress and the impact this had on others and to ensure DoLS application had been submitted within timescales. None of these issues had been referred to in the two subsequent audits although continued to be a concerns during our inspection.
● Records of people's care were not always personalised and lacked detail. Daily notes were recorded in a task focussed way and did not always provide detailed information. This meant information was not always shared in relation to people's preferences or their response to new things they may have tried. People's support files were difficult to navigate as information was disorganised.
● Records were not always securely stored to protect people and staff confidentiality. We asked a senior staff member for certain risk assessments, capacity assessments, best interest decisions and staff supervision notes. They told us senior staff would have completed these but may have stored them on either in their personal desktop folders or in their lockers. Senior managers assured us they would investigate this to ensure peoples confidential information was protected.
● Systems to monitor the training and support for staff were not effective. Managers had no oversight of which staff had completed training and we found multiple staff who had not been appropriately trained for their role.

The failure to ensure robust management oversight of the service was a failure of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others
● Relatives and professionals told us they experienced difficulties in gaining accurate information from the service. One relative told us, "We have asked and asked for information and answers but we don't get a response or the information is incomplete." One professional said, "We have constantly had to chase information from them. We have been told referrals have been made for[(person] and they haven't been done."
● Feedback from people, relatives and professionals was not routinely sought. Surveys to gather views had not been completed within the 12 months prior to our inspection. There had been no resident meetings held and reviews of people's care had not been consistent. Relatives told us they were not asked for feedback about their loved ones' care.
● Staff feedback was not always fully considered. Staff had identified some key themes for how to improve the quality of care, such as some staff needing to show more empathy to people, providing consistency by following care plans and more effective shift planning. These concerns had not been considered when completing the improvement action plan for the service.

The failure to ensure good governance was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

- The provider had been open and transparent with relatives regarding safeguarding concerns and the investigation process. Relatives confirmed they had received information and had been given the name of a senior manager they could contact should they wish to discuss concerns going forward.
- The provider was aware of their responsibilities in ensuring that CQC were notified of significant events which had occurred within the service. Notifications were forwarded to CQC as required.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The provider had failed to ensure people were consistently treated with respect.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider had failed to ensure the principles of the Mental Capacity Act 2005 were followed.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had failed to ensure people were supported by staff with the required knowledge and skill and that staff received the training and support required to support them in their roles.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider had failed to ensure people's needs were thoroughly assessed, that best practice guidance was followed, that people were supported to maintain a healthy weight and were provided choices in relation to their food and that people's health care needs were robustly assessed and monitored in line with people's needs. The provider had failed to ensure people had opportunities to do things they enjoyed.

The enforcement action we took:

We issued a Warning Notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to ensure robust safety, risk management and medicines practices were in place.

The enforcement action we took:

We issued a Warning Notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to ensure robust oversight and good governance

The enforcement action we took:

We issued a Warning Notice