The Oaklea Trust

The Oaklea Trust (North East)

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

The inspection took place on 12, 13 and 15 January 2016 and was announced. This meant we gave the provider 48 hours' notice of our intended visit to ensure someone would be available in the office to meet us.

The service was registered at the current location with CQC on 14 January 2015 and had not previously been inspected at this location. The service was inspected at a previous location in July 2013 and found to be compliant in all regulatory standards inspected.

The Oaklea Trust (North East) is a domiciliary care provider based in Durham providing personal care and support to people in their own homes throughout the north east. It provides support to people with learning disabilities and is registered with the Care Quality Commission to provide personal care. There were 53 people using the service at the time of our inspection.

The service had a registered manager in place. 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. The registered manager had worked for the provider since 2011.

We found the service took safeguarding training, concerns and notifications seriously to ensure people who used the service were protected. Where concerns were raised, we saw evidence staff and management had acted promptly to protect people. Staff we spoke with had a good understanding of safeguarding principles and procedures and we found these were clearly communicated through organisational policies and staff meetings.

We found that risks were managed and mitigated well through pre-assessment and ongoing assessment of people's environment and needs. People using the service told us they felt safe, whilst family members visiting healthcare professionals and local authority commissioning professionals raised no concerns about the safety of the service.

We saw people who used the service had individualised emergency and evacuation plans in place.

Medicines were managed and administered safely and we found no errors with the service's medicines record-keeping. Medicines records were regularly audited and the competence of people administering medicines was reviewed annually.

We found there to be sufficient numbers of staff on duty to meet the needs of people who used the service.

Staff underwent a range of pre-employment checks, including checks against the Disclosure and Barring

Service (DBS) barred lists and references from previous employers, to ensure they were suitable for the role.

We found that staff received an induction and a range of training the provider considered mandatory, such as safeguarding, moving and handling, infection control and health and safety. Staff also received training relevant to supporting the individual needs of people who used the service. Training needs were effectively managed and monitored by the Human Resources manager.

We saw that personal sensitive information was stored securely.

We found there to be consistent and comprehensive liaison with external healthcare professionals and other agencies in order to ensure people's healthcare needs were met.

People who used the service had developed trusting relationships with those who provided care and we observed a rapport between staff and people who used the service. Relatives told us without exception that staff displayed caring attitudes and treated people in a dignified manner.

We saw consent was integral to care plans and when we spoke with staff and the registered manager about their understanding of people's capacity, they were able to give detailed answers. The registered manager had liaised with the relevant local authority department to clarify their understanding of the impact of the Mental Capacity Act (MCA) on people who used the service.

Staff supervisions, appraisals and staff meetings all happened regularly and staff gave examples of the professional and personal support they received from immediate management and more corporately.

We saw that people were encouraged and supported to contribute to their own care planning and review, with family members similarly involved. Person Centre Plans (PCPs) were in place, specifically for people to set and achieve their own goals.

PCPs took whatever format the person wished and were tailored to people's individual interests. A range of hobbies, interests and aspirations were supported by staff and we saw numerous examples of people achieving a wide range of goals, which had significant positive impacts on their wellbeing and independence.

Staff supported people to achieve goals through helping them access the local community, volunteering opportunities, sporting endeavours and accessing an in-house charitable fund to further their independence. Staff were passionate about the achievements they could support people to make, in line with the service's stated visions and values and we saw staff put in additional effort to ensure people were able to achieve their aspirations. People who used the service took pride in their achievements and were supported to celebrate them and think of new goals.

Care plans were reviewed regularly and, where people's medical needs changed, these reviews were brought forward and care provision amended accordingly. People who used the service and healthcare professionals told us staff were accommodating to people's changing needs and preferences. We saw examples of care staff using innovative methods to support people to reduce potentially harmful behaviours.

The provider had a complaints policy in place. People who used the service and relatives were made aware of the complaints procedure and told us they knew how to make a complaint and who to. Complaints were considered and responded to in line with the policy.

People who used the service, relatives and healthcare professionals we spoke with were consistent in their praise of the leadership of the service. The registered manager and all staff we spoke with were consistent in their understanding of the principles of the service, as set out in the Statement of Purpose. All staff described the key objectives of their role as being to support people to be independent and to fulfil their own goals.

All people who used the service, relatives and external healthcare professionals we spoke with referenced positive interactions with the registered manager and team leaders, describing them as approachable and knowledgeable. We found this to be the case during our inspection.

An efficient auditing and quality assurance regime had been established organisationally and this had been welcomed and adapted by the registered manager, with improvements to the service instigated by audits and the annual report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

Where concerns were raised about people's safety the registered manager and staff acted quickly to make sure people who used the service were safe.

Risk assessments were detailed and regularly reviewed to make sure risks could be managed and mitigated.

Medicines were managed safely, with management oversight of staff competence through auditing and assessment.

Is the service effective?

Good

The service was effective.

Staff received an induction and a range of mandatory and non-mandatory training specific to the needs of people who used the service.

The registered manager had a good understanding of mental capacity and had sought guidance about how legislation would impact on people who used the service.

People were supported to enjoy their preferred meals and people with specialised diets were supported with involvement from relevant professionals.

Is the service caring?

Good

The service was caring.

Staff had formed trusting, meaningful relationships with people and treated people with dignity and respect.

People were supported to maintain other relationships important to them, such as relationships with family members.

People were given the opportunity to take part in interviews of prospective members of staff.

Is the service responsive?

Outstanding ☆

The service was extremely responsive.

Care plans were person-centred, whilst additional Person Centred Plans (PCPs) documented people's record of setting and achieving their own goals. People did this with the innovative support of staff, which led to outstanding examples of people achieving and maintaining independence.

Changing needs were identified promptly through regular reviews and staff ensured these needs were met through the involvement of other agencies.

The registered manager had implemented a new 'Going into Hospital Pack' following advice and support from a nationally recognised project to improve health outcomes for people with learning disabilities.

Is the service well-led?

Good ●

The service was well-led.

All care staff, team leaders and the registered manager were consistent and passionate about their main goal objective being to support people to meet their own goals.

The service was supported by strong corporate governance but also a registered manager that took responsibility for ensuring the service found ways to improve at a local level.

The registered manager and team leaders had an excellent knowledge of the needs of all people who used the service.

The Oaklea Trust (North East)

Detailed findings

Background to this inspection

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

The inspection took place on 12, 13 and 15 January 2016 and was announced. This meant we gave the provider 48 hours' notice of our intended visit to ensure someone would be available in the office to meet us.

The inspection team consisted of two adult social care inspectors.

During the inspection we reviewed five people's care files, looked at five staff records and reviewed a range of policies, procedures, audits, information management systems and notifications. We contacted five relatives of people who used the service by telephone. We also spoke with eight members of staff: the registered manager, one office-based member of staff and six care staff. We visited three people in their home and observed interactions between staff and people, as well as asking people about their experiences. We also spoke with two external healthcare professionals.

Before our inspection we reviewed all the information we held about the service. Prior to the inspection we spoke with the local authority, who raised no concerns about the service. We also examined notifications received by the Care Quality Commission.

Good

Is the service safe?

Our findings

People who used the service told us they felt safe. One person said, "Staff look after me," and we observed trusting and comfortable behaviours from people who used the service with staff who cared for them. When we spoke with relatives and healthcare professionals, they were unanimous in their confidence in the ability of individual staff and the service as a whole at maintaining people's safety. One relative told us, "There are always plenty of staff - no complaints at all," and another said, "I have no concerns at all."

We saw that an awareness of safeguarding principles formed part of staff inductions, whilst the subject was also a standing item on staff supervision documents. The safeguarding policy we reviewed was clear, comprehensive and accompanied by practical information for staff such as common indicators of abuse in people who are unable to verbally communicate and contact information for relevant external agencies. All members of staff we spoke with had a thorough understanding of safeguarding procedures the service had in place. Staff were able to talk in detail about their prospective actions should they have any concerns regarding abuse. We saw this had been put into practice recently when a member of staff raised concerns about the conduct of another. We saw the matter had been taken seriously and prompt, appropriate action had been taken by the registered manager. This demonstrated staff members were able to apply relevant safeguarding training and policies to ensure people who used the service were protected against potential abuse.

People who used the service and their relatives told us they knew who to contact should they have any concerns regarding people's safety and we saw contact information and processes for local safeguarding arrangements were visible in people's homes. All staff, people who used the service and relatives we spoke with felt staffing levels were appropriate to keep people safe. All people and relatives we spoke with confirmed carers arrived at the agreed times and no one we spoke with raised concerns about staff arriving late or missing a shift. This meant that people had not been placed at risk of neglect through understaffing.

We saw all staff underwent pre-employment checks including enhanced Disclosure and Barring Service checks. The Disclosure and Barring Service maintains records of people's criminal record and whether they are restricted from working with vulnerable groups. We also saw that the registered manager sought and verified at least two references and ensured proof of identity was provided by prospective employees prior to employment. We saw gaps in employment were explored with the staff member to ascertain their whereabouts when they were not in employment. This meant the service had in place a robust approach to vetting prospective members of staff, reducing the risk of an unsuitable person being employed to work with vulnerable people.

We reviewed procedures for the administration of medicines and sampled recent Medication Administration Reports (MARs). There were no errors in the records we reviewed. Allergies were noted and staff signature lists were in place. We saw the service had in place appropriate reporting systems in the event of a medicines error. For example, we saw that a tablet had been found in the folds of one person's clothing, but that all medicines were noted as administered. We saw staff instigated procedures as per the medication policy, informing senior staff who then conducted an investigation. It was established that the person had a

history of spitting out medicines and, whilst no disciplinary action followed, we saw the registered manager reiterated the need for all staff administering medicines to exercise vigilance when administering medicines.

We saw that staff were appropriately trained in the administration of medicines and had their competence regularly appraised. When we asked a range of staff about their understanding of people's individual medicinal needs and the relevant medicines procedures, they displayed a good understanding. We noted the service did not have in place body maps to support the administration of topical medicines. We spoke with the registered manager about this and, whilst they were able to show us that individual care plans did contain significant detail regarding where on the body a person required topical medicines to be applied, they acknowledged body maps would provide a better and safer means of supporting staff to apply such topical medicines. We found medicines administration generally to be safe, with control measures in place, and in line with Royal Pharmaceutical Society (RPS) guidelines on medicines administration in social care.

We saw risks assessments were put in place prior to people using the service. Staff undertook an initial visit to assess any immediate personal or environmental risks, such as fire or trip hazards. This helped to support staff and people who used the service to remain safe. Additionally, the service ensured each person had an annual Health and Safety Review, conducted by an external independent provider. We saw individualised risk assessments were then developed, regularly reviewed and updated where necessary. For example, one person was at risk of bullying and, as a result, engaging in anti-social behaviour themselves. We saw a tailored support plan included strategies to help the person de-escalate confrontation without restricting their freedoms, as well as agreed actions in the event of emergencies. We saw through implementation of the plan, the person had with support successfully managed situations that had previously led to confrontation. There was clear evidence the service protected against a range of risks through ongoing reviews.

We saw that accidents and incidents were recorded and acted on, with investigations undertaken and information sought from and shared with relevant agencies.

Relevant polices were in place to support staff in their roles and to keep people who used the service safe. For example, the whistleblowing policy was clear about staff actions and the support they would receive should they raise concerns about the service. The registered manager confirmed there was no staff member currently being taken through the disciplinary procedures. We found the disciplinary policy to be up to date and easy to follow, with template documents attached for ease and consistency of use. Likewise the lone working policy was detailed and included a range of scenarios so staff were informed regarding their responsibilities and the need for vigilance whilst working alone.

Good

Is the service effective?

Our findings

One healthcare professional told us, "We never have any issues – I think training is the key." One relative told us, "Both keyworkers are excellent." People who used the service expressed confidence in staff, with one person saying, "Very good, everyone knows me," when we asked them whether staff looked after them.

We looked at staff training records and saw all staff had received a range of training considered mandatory by the provider, such as safeguarding, infection control, first aid, moving and handling, medicines administration, autism awareness and dementia awareness. We saw training was also delivered specific to the needs of people who used the service, for example epilepsy awareness training and percutaneous endoscopic gastrostomy (PEG) feeding training. A PEG is a tube passed into a patient's stomach through the abdominal wall as a means of feeding when oral intake is not possible or adequate. Staff had also recently increased their knowledge and ability to support people's needs flexibly. For example, the provider had arranged for staff to be trained to take blood pressure measurements, previously a task undertaken by external healthcare professionals. This meant staff were able to meet more of people's needs through focussed training on particular aspects of care.

We saw recent members of staff had begun completing the Care Certificate. The Care Certificate is a set of standards that health and social care workers adhere to in their daily working life. We saw that existing members of staff would also be given the opportunity to complete individual modules from the Care Certificate. We also saw that care managers met regularly to discuss learning from the implementation of the Care Certificate, so that those managers without new staff could benefit from the lessons learned by those who did have staff completing the process. This meant the owner and registered manager had regard to industry best practice when delivering training and incorporated updates to best practice into its induction of new staff.

When we questioned staff on their understanding of these aspects of training, their responses were informed and had regard to the training delivered, for example PEG training and epilepsy awareness training.

Training was monitored via a training matrix, a document which held information regarding every training course staff had attended or were due to attend. This information was used to inform management meetings so that managers could ensure refresher training was booked in time. This document also contained staff supervision and appraisal information. Staff supervision meetings between a member of staff and their manager reviewed progress, addressed any concerns and looked at future training needs. Managers therefore had the tools to identify when staff members were due to revisit aspects of training and support to perform their role.

All staff we spoke with told us the system worked well, and that they were suitably supported to care for people. One said, "The training is very good," whilst another confirmed, "The support we get is excellent – plenty of supervision meetings and we have an annual appraisal."

Staff confirmed they had received an induction process in line with that outlined by the registered manager.

With regard to more informal support, staff were positive, stating, "If we need support, they are very approachable," and confirmed that office staff were readily available if they had queries or concerns. We also saw there were regular staff meetings, with the registered manager holding group supervisions when the need arose, for example to communicate an immediate change to policy. In addition to staff meetings, there was also an Employee Consultation Group, which met regularly and was represented by staff in care roles from the provider's registered locations. We spoke with the Oaklea Trust (North East) representative, who valued the forum as a means of raising issues, sharing best practice and seeking support from peers and management colleagues across the organisation.

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.

We found the service was working within the principles of the MCA. The registered manager and all staff we spoke with demonstrated a good understanding of consent and mental capacity considerations. We saw the registered manager had sought advice from external agencies regarding implementation and understanding of the MCA. We saw detailed mental capacity assessments in place and considerations of consent and, where appropriate, best interests decision-making in care planning and delivery.

Care plans had regard to people's right, where they had capacity, to make decisions regarding their lifestyle. For example, we saw in one persons' care plan a detailed person-centred description of their likes and dislikes and how they enjoyed cigarettes. We saw staff had a range of strategies in place through a 'Positive Support Plan' to help the person reduce their nicotine intake, such as alternative healthy activities and attending support groups. We also saw that care plans acknowledged the person's right to make this choice. We saw people's right to be involved in decisions about their own care was consistently upheld and respected.

With regard to nutrition, we saw people who required specialised diets, for example people with diabetes, were carefully supported. Meal planning had regard to information on file from the National Patient Safety Agency and where specific advice had been sought from Speech and Language Therapists (SALT) we saw this had been incorporated into people's care plans. We also saw people who were at risk of malnutrition or, conversely, putting on weight, were regularly weighed and supported to regular GP appointments to monitor their weight. People were supported to enjoy their preferred meals.

Staff communicated effectively and efficiently with other agencies to provide care that met the needs and preferences of people who used the service. We saw evidence of advice sought and referrals made to a range of specialists and other healthcare professionals. When we spoke with healthcare professionals they were satisfied with the information they received from staff and the knowledge staff had of the people they cared for.

Good

Is the service caring?

Our findings

People who used the service told us without exception that they were happy with the care provided by staff. One person told us, "I'm very happy with everyone." We saw people who used the service had formed strong, trusting bonds with staff. When we visited the home of three service users, they introduced us to their keyworker and gave examples of the ways they enjoyed spending time with them. People who used the service had clearly built a rapport with their keyworkers and were able to instigate jokes based on common experiences and understandings.

Family members we spoke with gave similar examples of positive relationships being formed. One relative told us, "The staff treat him and us just like family, they are so kind and caring." Another relative said, "The staff are all kind, caring and considerate. I am always made to feel welcome when I visit." One external healthcare professional said, "There's a high standard of care," whilst another told us about how the service had liaised with a hospital when a person who used the service was taken ill to ensure aspects of their care could still be delivered by staff familiar to them.

All staff we spoke with had an excellent knowledge of people's histories, likes and preferences and we found staff followed the workplace behaviours set out in the service's literature, particularly, "We work together to increase independence and quality of life." This theme was consistent in the feedback we received from people who used the service and their relatives, as well as documentary evidence. For example, we saw one person who had previously been unable to go to the local shop unsupported now did this regularly. Another person was supported to visit places throughout the region in their car. They kept a large map with each place they had visited listed and where they planned to visit next. They took pride in their car, displaying photographs of them and their car. One relative said, "[Relative's] quality of life was so much better since coming to live there." These examples demonstrated the service's focus on ensuring people were supported to gain and maintain independence.

People were supported to maintain relationships meaningful to them, for example with members of their family. When we spoke to family members they confirmed the service ensured people were able to visit them at times convenient to the person. We also saw evidence that the service had enquired with a local organisation supporting people with learning disabilities regarding their ability to host/facilitate dating opportunities for people who used the service. Whilst the registered manager had not finalised how this might work, it demonstrated they took seriously people's rights and pro-actively pursued means of supporting people to pursue their own sexuality or need for companionship.

Due to the low turnover of staff and the fact the majority of staff had worked for the service for a number of years, people who used the service were supported by staff familiar to them. All people we spoke with recognised the value of this continuity of care for people who used the service. The importance of a familiarity and continuity of care was recognised in recent best practice guidance from NICE ('Home Care: Delivering Personal Care and Practical Support to Older People Living in their Own Homes,' September 2015). We found people who used the service received high levels of continuity of care.

Another means by which the registered manager ensured people felt a part of their care provision was to involve people who used the service in the interview process, where they chose to do so. Staff agreed this was a positive means of ensuring people were satisfied with the carers who would be supporting them but also that the service could establish how prospective members of staff would interact with the people they might care for in the future.

We observed staff treating people who used the service with dignity and respect. People who used the service and relatives confirmed this was how they were treated by staff.

Where people who used the service had been assessed as unable to make a specific decision because they lacked capacity we saw staff had identified this and ensured other agencies were involved to provide advocacy support for people. Similarly, we saw the registered manager and other staff involved people's relatives in care planning and review, valuing their knowledge and allowing them to provide a more informal kind of advocacy.

With regard to communication, we saw care plans were detailed in their description of how people's particular communicative abilities could best be supported, whether through the use of symbols or through staff speaking in a particular way during certain aspects of care. The service also had in place the Disability Distress Assessment Tool (DISDAT) to help identify when a person who was unable to verbally communicate was experiencing distress. The DISDAT tool helps identify distress in people who have limited communication abilities. We found this tool had been completed in detail and when we spoke with staff they displayed a good knowledge of people's non-verbal communication abilities and choices.

We saw sensitive personal information was stored securely in locked cabinets and the entrance to the service's office was via a door requiring a security fob. This meant people could be assured their sensitive information was treated securely.

Outstanding ☆

Is the service responsive?

Our findings

People who used the service took pride in showing us the range of activities and interests they were able to pursue with the support of staff. People planned these activities via regular meetings with staff and documented achievements in their 'Person Centred Plans' (PCPs). Each PCP was specific to each individual and could take the form of a lever-arch file full of information, a box of craft items, photographs and pertinent information or, in some cases, arrangement of photographs, drawings and achievements displayed on a wall. One person had chosen a Formula One theme for their wall, whilst another had incorporated their interest in ten-pin bowling and celebrities on their PCP wall. This meant people were able to see and had the opportunity to access the things they enjoyed and the positive things in their lives.

We explored the content of PCPs further and found evidence that staff used a range of methods to ensure people who used the service could identify and meet their own goals. For example, one person's goal was to learn to cycle, as they had never done this as a child. We saw that staff made a successful application to the internal 'Wishlist' fund, meaning they could purchase a tricycle for the person (along with a basket and safety equipment). The person told us they, "Loved" the tricycle and regularly used it to got to the shops, as well as on outings with other people who used the service.

The 'Wishlist' is an Oaklea internal charitable fund to which staff from the provider's locations can apply for additional funding to support people to achieve a particular goal. We saw another recent example of people who used the service benefitting from this. Staff had been encouraged to take part in a 'Dragon's Den' style pitch to senior management for 'Wishlist' funding at a recent staff celebration. We saw a staff member at The Oaklea Trust (North East) had discussed a range of options with people they supported and agreed to pitch for funds for the 'John Street Jammers'. This would involve people who used the service making jam and selling it locally. When we spoke with people who used the service they told us how excited they were to be making the jam and selling it locally. We also saw they were due to attend a food hygiene and labelling course. This meant people who used the service were learning new skills, engaging in activities meaningful to them, socialising with people in the community, as well as selling products they made, with profits going back into the 'Wishlist' fund.

We saw one person's PCP contained sporting awards. They told us staff encouraged them to play sport, at which they excelled, including swimming, where they had been supported to attend the Special Olympics Great Britain. They told us about their love of horses and we saw how staff had supported them to attend a voluntary placement at a local stables and riding centre. They had thrived at this placement and were described as, "An extremely valuable member of the team" by staff at the stables, who cited a range of skills the person had developed whilst at the stables. A local television news report covered the work of the riding centre and the person who used the service appeared on TV and was interviewed. Staff subsequently contacted the television company and obtained DVD copies of the footage so the person could relive and share the achievement. The person took great pride sharing this footage with us during our inspection.

The Customer Handbook, given to all people who used the service, begins, "The Oaklea Trust is a charity with a vision based on the principle that everyone has a positive contribution to make to society and the

right to control their own lives." The mission statement in the Statement of Purpose read, "To support disabled and disadvantaged people towards independence through choice and inclusion," whilst the first of the six 'Workplace Behaviours' was, "We work together to increase independence and quality of life." We found comprehensive evidence that staff achieved these principles through providing person-centred care to people who were in turn supported to achieve a diverse range of goals.

With regard to preventing the risk of social isolation, staff did this through its ongoing focus on promoting people's goals and independence and celebrating those successes. For example, one person who used the service enjoyed reading the 'reader's poem of the day' in a local paper and set themselves a goal of having a poem published in the paper. We saw they had been supported to achieve this by their keyworker, who had written a pen picture of the person so that editorial staff were able to get to know the person's history and decide whether they would include the poem for publication. They did so and the poet was extremely proud of this achievement, telling us about the next poem they planned to write, as well as their other arts and crafts projects they were working on.

They praised the ability of staff to support them in their varied interests and we found a range of evidence that staff did not see age as a barrier to pursuing goals meaningful to people.

Staff respected people's interests and we saw that, where it was one person's preference not to have a PCP updated, this was respected. Likewise we saw one person's My Life, My Choices file contained very clear instructions to staff about their preferences: "If I don't want to go somewhere I occasionally explain to you the reason why I don't; I still want to be given the opportunity." This meant care planning had regard to people's right to be as independent and socially outgoing as they wanted to be, without taking a blanket approach to activity planning.

We saw care plans, held in what was known as the 'My Life, My Choices' file, were person centred and were in plain language. Staff had ensured care plans were written with the person's voice and conveyed their personality. We saw these documents were regularly reviewed and, when we spoke with relatives, they confirmed they were always invited to attend reviews of care plans.

There was a significant amount of accessible detail in each care file we reviewed, meaning any new member of staff would have access to a considerable amount of pertinent information before providing care to a person. Similarly, the detail of daily care notes meant there was a comprehensive audit trail of people's care, making staff accountable but also meaning external professionals had access to a detailed history of a person's needs.

In addition to care files, each person had a 'Hospital Passport.' A hospital passport documents essential information that can be used by other healthcare professionals if a person is admitted to hospital. We saw the registered manager had sought advice from external professionals regarding how to make this system more representative of people who had difficulties communicating verbally. The impact of this was that external healthcare professionals who people came into contact with had a better understanding of how best to communicate with them. We found the tailoring of communication information to be in line with the 'Five good communication standards,' as outlined by the Royal College of Speech and Language Therapists in their 'Five Good Communication Standards', 2013.

With regard to people's medical needs, we found staff liaised promptly and pro-actively with a range of external healthcare professionals. One such professional told us, "They are very responsive and we have good working relationships," whilst another said, "They pre-empt things that might happen and are always in touch with any concerns." We saw advice from an occupational therapist had been sought on a number

of occasions to ensure people's environments were best suited and adapted to their needs. Where advice was provided by such professionals, we saw this had been incorporated into care plans.

We saw staff were prepared to find innovative means of supporting people's particular needs. For example, one person had a history of harmful behaviours. They also had a particular interest in tattoos. We saw how one member of staff, in addition to support from external specialists, had used this information about the person's likes to bring about a reduction in harmful incidents. They painted 'tattoos' on the person's arms using face paints. We saw the person showed these 'tattoos' off and was proud of them. One external social care professional confirmed they had noted a downturn in the number of harmful incidents and the strategy had brought about results. We saw the approach by staff had a positive impact on the person's wellbeing.

The service had a complaints policy in place and we saw complaints had been managed and responded to in line with the procedures outlined therein. When we asked people who used the service and their relatives if they knew how to complain and who to they were confident to do so. This meant people were supported to raise concerns should they need to.

Good

Is the service well-led?

Our findings

At the time of our inspection, the service had a registered manager in place. The registered manager had worked for the provider since 2011, at this location and the location's previous registered address. The registered manager had significant relevant experience in health and social care.

People who used the service and their relatives told us they had confidence in the management of the service. One relative said, "The service is very well managed and they always keep me informed about her care and welfare." Staff were without exception positive about managerial and organisational support. One said, "I can only give positives – if I am ever worried I am always able to go to [team leader]." Another told us, "[Registered manager] pops through and does audits and checks. They are very personable and we have a rapport. They're always there at the end of the phone if we need them."

The service was managed by geographical 'zones', with one manager overseeing the zone, then team leaders managing care staff (who were known as Lifestyle Co-ordinators). We saw the registered manager met with the team leaders each month and discussed issues such as whether care plans were up to date, or whether the team leader required additional support. These meetings took place in people's houses, with their permission, meaning the registered manager also used the opportunity to maintain contact with people who used the service. When we spoke with the registered manager they had a good knowledge and understanding of people's needs across the service. We noted a painting of a daffodil on the wall of the office and the registered manager told us a person who used the service had painted it for them. We later spoke to that person and found the registered manager's knowledge to be accurate and up to date.

Staff we spoke with confirmed they were provided with good levels of support. They felt managers were accountable and shared areas of best practice. One staff member said, "They have been supportive and quite pro-active about me moving into a new role. We share best practice and support each other." Another staff member told us how supportive the registered manager had been when they had required time off due to personal matters. Another said, "[Registered manager] is a familiar face," and told us they felt the registered manager was aware of any local issues.

We also saw that one trustee of the board would visit people who used the service annually and report their findings back to the board. We also saw one person who used the service was a member of the board. This meant people who used the service were involved with the service at a corporate level.

We saw evidence that higher levels of management took an interest in the day-to-day running of the service and the outcomes for people who used the service. For example, the Chief Executive Officer (CEO) regularly attended the Employer Consultation Group. The employee representative we spoke with told us they valued this input and the fact it made senior leaders feel, "Involved and interested." We also saw a letter from the CEO to a person who used the service, congratulating them on their sporting achievements.
The registered manager displayed a good knowledge of the Social Care Commitment and the Learning Disabilities Health Charter. The Charter is a charity-led (Voluntary Organisations Disability Group) approach designed to "Support social care providers to improve the health and well-being of people with learning

disabilities, thus improving people's quality of life generally." We saw the implementation of the charter had already led to one change to care practices, namely the introduction of more detailed 'Going into Hospital' packs. We saw these provided much more personalised information than the Hospital Passports, which were also contained in the pack. The Social Care Commitment requires a service to promise to uphold standards for people who need care and support. We noted the Commitment was yet to be fully implemented but we saw staff had been involved in discussions prior to the service signing up to the Social Care Commitment and were keen to be involved.
We saw there was a strong auditing and quality assurance culture within the service and more broadly across the organisation. For example, the provider produced an annual report in light of returned surveys from people who used the service and relatives. This report identified areas where there were opportunities for continuous improvement, such as ensuring the 5 principles of the Mental Capacity Act (MCA) were incorporated into care plans, and ensuring the Care Certificate was implemented consistently. We saw, at a local level, that this plan had been reproduced to include all the relevant aspects for the service on their Continuous Improvement Plan 2015/2016. We checked a number of the actions set out in the plan and found them to have been completed or in progress. This meant the registered manager was supported with guidance from the provider and took responsibility for ensuring continuous improvement was a key part of their role.

We noted that, whilst the annual reports and actions were informed by responses to surveys by staff, relatives and people who used the service, the content of these surveys were not immediately accessible, having been archived electronically. This meant the service could miss an opportunity to use qualitative feedback, such as a specific concern by a person who used the service, or likewise miss the opportunity to celebrate success by reflecting on particular comments.

We saw individual audits undertaken by the registered manager, such as the Medication Administration Records (MARs), daily notes, accidents and incidents and staffing levels. We also saw all aspects of Human Resources were undertaken by a manager with that specific role. This meant the service was well supported to identify errors or trends within service delivery that required improvement. We found audits to be effective. For example, one audit identified that induction packs were not consistent in that staff supporting people with learning disabilities did not receive an induction pack as detailed as staff who supported older people in other Oaklea services. We saw this had been queried internally and rectified.

When we asked members of staff about what service they provide to people, every staff member began by describing their focus on supporting people to gain and maintain independence and to, "Help people achieve their goals." This was in line with the provider's stated key objective and demonstrated the registered manager and others had ensured the culture at the service was one geared towards the goals and aspirations of people who used the service.

We saw support at a more strategic level was similarly geared towards outcomes for people who used the service, with newsletters including, for example, news about the person whose poem was published in a local newspaper. The provider also had in place a scheme known as 'Wishlist', which was an in-house charitable fund which people who used the service and staff could apply to for help with specific projects or equipment.

The registered manager, team leaders and lifestyle co-ordinators had established positive community links through events such as coffee mornings, a Halloween party and volunteering placements for people who used the service with, for example, garden centres, riding centres and charity shops.

We found records to be in good order and all notifications previously sent to CQC were easily accessible,

alongside policies and procedures. We found care file information and policies to be up to date and accurate. Where policies were updated in line with current guidance and legislation we saw they had been signed and dated.