Calton Systems Limited

Oaklands House

Inspection report

119 Rochdale Road
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Tel: 01706750790

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

We inspected Oaklands House on 16 April 2018. This was an unannounced inspection.

At our last inspection in October 2016 we rated the service good. At this inspection we found the evidence continued to support the rating of good and there was no evidence or information from our inspection and ongoing monitoring that demonstrated serious risks or concerns.

Oaklands House is in Milnrow, Rochdale and consists of a large period building that has been extended to provide 13 single bedrooms for people who are diagnosed with mental health problems and are over the age of 18 years. The home provides 24 hour care and has a wide range of equipment and facilities to assist people with their care needs. At the time of our inspection the home was full with 13 people living in the property. There was enough room to allow for privacy and communal living. People had their own rooms, which were decorated to reflect their personal taste, and there were a number of communal areas which were well furnished and laid out with consideration of the needs of those who used the service. All areas were clean with close attention paid to minimising the risk of infection.

The home was secure, and there were no undue restrictions on people who were supported to maintain their independence. People told us that they felt safe and when we spoke with staff they demonstrated a good understanding of how to prevent abuse. The service had safeguarding procedures which were in line with legislation and local authority policies so when incidents of potential abuse occurred these were reported and appropriate action taken to protect people from harm.

Care records showed that risks to people's health and well-being had been identified, and where risk had been identified, corresponding detailed care plans were put into place, and reviewed on a regular basis. Risks were assessed in relation to each individual, taking into consideration their choices, abilities and lifestyle.

We saw that when recruiting new staff, appropriate processes were in place to ensure that they had the right quality and character to work with vulnerable people. Once in post all staff received regular supervision and appraisal and were provided with training opportunities to develop their skills. There were sufficient staff on duty, and we saw that there was a low turnover of staff. Care workers knew the people they supported and had time to spend talking and interacting positively with them.

Medicines were well managed and records showed that regular audits ensured that people received their medicines safely and effectively.

There was evidence to show good cooperation with health and social services professionals, and staff at Oaklands House showed knowledge of people who used the service. Needs were met in a person centred way. Staff were well trained and training needs were monitored, with refresher training on a regular basis. Staff told us they found their supervision sessions to be useful and helped them with their daily tasks.

People who used the service influenced the food provision, and when we spoke with them they told us they liked the food on offer. Dietary requirements were met, and individual tastes and preferences were catered for.

People who used the service were offered choices, and capacity and consent issues were considered. Where people lacked capacity, best interest decisions were taken and documented to show that decisions made were in their best interests. Where people were subject to a deprivation of liberty the service sought the appropriate authorisation to provide care and support.

The service recognised and responded well to people's needs and wishes and people were treated with respect and dignity by kind and patient staff. People who used the service said they felt valued and included, and that their privacy was respected. All were comfortable in their surroundings. They were involved in planning their care and reviews and their wishes and needs were considered and acted upon. A complaints procedure was available and people told us that they knew who to speak to if they wanted to make a complaint.

To help ensure that people received safe and effective care, systems were in place to monitor the quality of the service provided, and ensure good recording of information. Communication amongst staff ensured that information was passed on in a timely manner. The service sought the views of people who used the service and other stakeholders to provide and improve on service delivery.

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.

The building was secure, clean and well maintained.

There were enough staff who were safely recruited and knew how to protect people from harm.

Care records informed staff how to minimise risks in relation to people's health and wellbeing.

Is the service effective?

Good

The service was effective.

Staff were well trained, and knowledgeable. They communicated well with each other to ensure care needs were met in a consistent manner, and had regular supervision.

People enjoyed the food provided, and had good access to healthcare. Staff monitored their physical and mental health needs.

Staff showed an understanding of capacity and consent issues. Where people were being deprived of their liberty the registered manager had taken the necessary action to ensure that people's rights were considered and protected.

Is the service caring?

Good

The service was caring.

Staff were caring and kind and provided support in a way which reflected people's wishes.

Staff took steps to maintain people's dignity, privacy and maintain levels of independence.

Is the service responsive?

Good

The service was responsive.

People's care records were person centred and reflected their care and support needs.

People were stimulated and encouraged to maintain their interests and hobbies.

Where a complaint was received, this was investigated and feedback was provided to the complainant.

Is the service well-led?

Good

The service was well led.

People felt they had a say in how their needs were addressed.

Systems were in place to assess and monitor the quality of service provision, and the service had developed good systems to audit the quality of care provision.

The manager and registered provider understood their legal obligation to inform CQC of any incidents that had occurred at the service.

Oaklands House

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 checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 16 April 2018 and was unannounced. The inspection was carried out by one adult social care inspector.

Before the inspection we looked at previous inspection reports and notifications received from the provider. A notification is information about important events which the provider is required to tell us about by law. We reviewed the Provider Information Record (PIR) before the inspection. This is a form that asks the provider to give some key information about the service, this tells us what the service does well and the improvements they plan to make. We used this information to help plan the inspection. We also checked with the local authority and health commissioning and safeguarding teams, and infection prevention and control team. They informed us that they did not have any concerns about Oaklands House and were satisfied with the level of care provided.

We spoke with five people who used the service, the registered manager, deputy manager and four other people who worked at the service. Before our inspection we contacted the health and local authority commissioning and safeguarding teams. During the inspection we spoke with three visiting professionals.

We observed the support provided by staff in communal areas of the home. We looked at the care records for three people and the medicines administration records for four people who used the service. We also looked at the recruitment, training and supervision records for three members of staff, minutes of meetings and a variety of other records related to the management of the service.

Good

Is the service safe?

Our findings

When we asked people who lived at Oaklands House if they felt safe they told us they did. One person remarked, "Oh yes, I feel safe, I can't find any faults here. I'm well looked after, staff are extremely polite and caring; they are always ready to listen, and spend time with us. They make me feel at ease".

The home was secure. All visitors were asked for identity and asked to sign in before entering the building, and all the people who lived at Oaklands House had mobile phones, and were reminded to take these with them when they went out unescorted. A list of numbers was kept in the staff office so people could be contacted if necessary. One person told us, "I always tell the staff when I am going out, and when I'll be back. I sign in and out when I am going."

Staff were mindful of any environmental issues and would record any concerns, such as loose tiles or broken cupboards. We saw that these were logged in a maintenance book, and repairs or replacements were carried out to ensure a safe environment. Nightly checks ensured that all windows and doors were locked and electrical and gas appliances were switched off to minimise the risk of fire. We saw staff were vigilant to people who use the service and how they interacted with each other, watchful for signs of conflict and to prevent any flashpoints.

Policies and procedures, including safeguarding and whistleblowing were designed to minimise the risk of harm. Whistleblowing provides a commitment by the service to encourage staff to report genuine concerns around poor practice without recrimination. Records showed that all staff had received training in these areas. When we spoke with them they were able to explain how they ensured people were safe, and tell us how they would respond if they suspected a person who used the service was at risk of harm. The safeguarding policy met the requirements of the Local Adult Safeguarding Board. Where incidents of potential abuse had been reported there was evidence of follow up investigation, appropriate recording and analysis with protection plans put in place. For example, where one person's behaviour increased the risk of physical and emotional abuse of other people, protective measures, including providing extra support and closer monitoring of communal areas ensured that people would remain safe.

The service respected and protected people's rights. For example, people were free to walk throughout the building and in a secure garden to the rear of the building, and visitors were welcome at any time. Unless there were any legal restrictions on people, they were free to leave the premises unescorted if they wished. Most of the people who used the service smoked, and at the time of our inspection a conservatory next to the back entrance was used as a smoking area, although a smoking shelter had been built in the garden. The people who used the service had agreed to this, which was to become operational once a ramp had been fitted. This would ensure all people could safely get out through the rear entrance. Some people had agreed to their tobacco and lighters being kept in the main office for fire safety reasons, but we saw there were no restrictions on when or how often they could request a cigarette.

We looked at four care records, which showed that risks to people's health and well-being had been identified. These included risks around physical and environmental needs, risks relating to mental health

issues, such as self-harm or risk to other people, financial risks and lifestyle risks. Each risk assessment was specific to the person, and where risk was identified a corresponding and detailed care plan was in place to help reduce or eliminate the identified risks. Risk assessments were reviewed on a regular basis.

The service recognised that people had the right to make their own decisions, but due to their underlying mental health needs people who used the service could sometimes make choices which increased the risk to their own well-being. This could be compounded by underlying cultural and sociological issues which could lead to legal concerns, such as illicit drug use. We saw that the service worked closely with individuals to understand the risks their behaviour may cause. They cooperated with other agencies, including mental health teams and community police to help reduce the likelihood of risk occurring. In addition they recognised that when decisions taken by individuals impacted on others they worked closely with the person and their representatives to negotiate and seek agreement, including signed behavioural contracts, to limit the effect of any decisions taken on other people who lived at Oaklands House. While risks remained, they were well managed with people being encouraged to take personal responsibility and consider the needs and wishes of other people who used the service.

We saw that there was a good ratio of staff to people who used the service. The staff rota showed that there were two care assistants on duty during the day and evening. One member of staff would work through the evening and sleep over at the service. All staff were rostered on a duty rota to respond to any incidents or emergencies during the night. There was some flexibility should needs change, for example, if a person's behaviour required a greater level of supervision or oversight. In addition, the manager and assistant manager worked each day of the week with alternating weekends off.

We looked at recruitment procedures which gave clear guidance on how staff were to be properly and safely recruited. This helped to protect the safety of people living at Oaklands House. We looked at three staff personnel files. These contained proof of identity, an application form that documented a full employment history and accounts for any gaps in employment, and interview notes. There were also two references and a medical questionnaire. Checks were carried out with the Disclosure and Barring Service (DBS) before any member of staff began work. The DBS identifies people who are barred from working with children and vulnerable adults and informs the service provider of any criminal convictions noted against the applicant. This meant that checks had been completed to reduce the risk of unsuitable staffing being employed at Oaklands House.

We looked at the systems in place for the ordering, management and administration of medicines. Some of the people who used the service were encouraged and supported to self-administer their own medicines. Where this was the case a risk assessment had been completed, to ensure that they were able to do this safely. Where people required assistance appropriate policies in place informed staff of all aspects of medicine administration, and these were followed by all staff, who had been trained to administer medicines and were checked on a regular basis by the registered manager.

We looked at four medicines administration records (MARs) and found they had been completed accurately. There were no unexplained gaps or omissions. Two staff members had signed they had checked medicines into the home which helped staff check the numbers of medicines people had. There was a photograph on each MAR to help staff identify the correct person.

The service did not have any controlled drugs on the premises but staff were aware of the storage and recording of these stronger medicines should they be prescribed.

Any medicines that had a used by date had been signed and dated by the carer who had first used it. This

ensured staff were aware if the medicine was going out of date. There was also a safe system for disposal. Any hand written prescriptions were signed by two staff which is the recommended safe method.

There were clear instructions for 'when required' medicines. The instructions gave staff details which included the name and strength of the medicine, the dose to be given, the maximum dose in a 24 hour period, the route it should be given and what it was for. This helped prevent errors.

During the tour of the building we saw the home was clean, tidy and did not contain any offensive odours. We saw that all rooms or cupboards that contained chemicals or cleaning agents were locked for the safety of people who used the service. A full time domestic assistant ensured that high standards of cleanliness were maintained, and we observed that care staff would support this person and ensure that they tidied after completing any tasks. A visiting professional told us, "It's always clean and neat, like stepping into someone's living room." Before our inspection we spoke with a member of the health authority infection prevention team who told us the service had received a 'green rating' which meant that the highest standards of infection control had been maintained. There was a laundry which contained enough equipment to help keep people's clothes clean and presentable. There were hand washing facilities in strategic areas for staff to use in order to prevent the spread of infection, including the laundry area. Staff had access to personal protective equipment (PPE) such as gloves and aprons and we saw that there were plenty of supplies.

We saw accidents and incidents were logged as soon as this was practicable. All incidents were logged and recorded on a summary sheet which showed what and how the incident occurred. A more detailed incident analysis provided greater detail and detailed the event, with advice to follow to prevent repetition, and learning from the experience to ensure mistakes were not repeated. Similarly the service saw criticism as a way of improving service delivery. For example, at our last inspection we noted that people told us they lacked the confidence to complain. In response, the service had introduced a 'resident's representative' who lives at Oaklands House to support people to speak up and sent a number of the people they supported on autonomy and well-being courses. This had empowered people who used the service who felt they were able to raise issues of concern.

Good

Is the service effective?

Our findings

The service worked closely with external bodies such as the community mental health team and advocacy services to ensure that care and support was delivered in line with current best practice and legislation, but took into account the specific and individual needs and wishes of the people supported. These needs were reviewed on a monthly basis with the individual to ensure that issues of concern were not overlooked. We saw that people had contributed to the development of their care plans and were consulted about how they wanted to live their life. Staff demonstrated a good understanding of the people they supported and this allowed for proactive intervention to minimise risk and respond to needs in a way which suited the person. Where people were unable to speak for themselves, the service ensured that an independent advocate was appointed to give them a voice.

During our inspection we saw efficient cooperation between all staff and management. Activities throughout the day were well coordinated and organised to ensure the smooth running of the service. We saw that people who used the service received effective care and support from well trained and well supported staff. Discussions with the manager, observations and conversations with staff showed they had an in depth knowledge and understanding of the needs of the people they were looking after.

When they were recruited all staff undertook an induction over thirteen weeks, including a minimum of thirty-six hours of observed practice to ensure that they were able to support people as they would like to be supported. During this period, they also undertook training in essential aspects of the job, and were supported to achieve nationally recognised qualifications in health and social care such as National Vocational Qualifications (NVQ) or Health and Social Care accredited qualifications. New care workers were enrolled on the 'Care Certificate'. This is a nationally recognised qualification for people working in the caring sector.

The training records we looked at confirmed that staff had received training relevant to their role, including health and safety, infection control, dignity in care, food hygiene, challenging behaviour, first aid, moving and handling and palliative care. The registered manager gave us a copy of the training matrix, which showed oversight of the level of training undertaken by staff. We saw that all staff (bar one, who had been on sick leave) had completed essential training with dates when refresher training had been completed or was due to take place.

Supervision offers staff an opportunity to discuss issues relating to their work and ensures systems are in place for monitoring the performance of individual staff members and for allowing collective understanding of issues or concerns. When we spoke with staff members they told us they received instruction and were supported 'on the job' by the manager and deputy manager, and had regular supervision meetings with the registered manager which they found these meetings useful. Records showed staff received a formal supervision every three months, although one record had not been dated.

Attention was paid to people's dietary needs. Snacks were available throughout the day as were hot and cold drinks. Some people had told staff that they wanted to lose weight, and had been supported to choose

a weight reducing regime that met their needs, and we saw that their meals were prepared in accordance with their wishes. At the time of our inspection, nobody who was supported at Oaklands House required meals that were prepared in accordance with specific dietary need, such as mashed or pureed to help with swallow, or fortified to assist people to maintain and increase weight. However, staff were knowledgeable about what actions to take in such circumstances. They would implement food and fluid charts to record and monitor food and fluid intake, and seek specialist advice if concerns continued. Previously, we were told that people who used the service had followed religious observance regarding food and diet, and staff were aware of their needs and how food should be prepared. Some of the people who used the service were practising Roman Catholics. They told us they liked to eat fish on Fridays, which was provided.

Care staff on duty prepared and cooked meals and people who used the service told us they were very much involved in what they ate. They were consulted to plan the weekly menu and encouraged to help in the kitchen, either assisting with meal preparation or helping with washing and cleaning. This enabled them to maintain their skills and increase their independence. We saw one person who used the service was happy to go to the supermarket with a member of staff to assist with the shopping. When we asked, people supported to live at Oaklands House told us they enjoyed the food on offer. One person told us, "Meals are beautiful. If I'm not happy they'll give me something else". We saw the weekly menu had some gaps. We were told that this was open for discussion and suggestions form the people who used the service. During the handover we observed meals for the day were discussed. Staff had noticed that a Sunday roast had fallen out of favour, so a buffet had been arranged instead. This was well received by people who used the service, but they had commented that they would miss roast chicken, so this was added as a midweek meal.

Communication amongst staff was good before, during and after each shift. We saw staff worked well together to ensure no tasks were left undone, and they cooperated well. One member of staff we spoke with told us, "It's a brilliant team, best I've ever worked in and I don't say that lightly". At the start of each shift all staff were included in a handover meeting where interventions with each person who used the service were discussed, noting any concerns or needs, and the day's tasks would be fairly allocated. We saw that staff meetings were held on a regular basis; the registered manager told us these would be as and when needed to discuss any changes or requirements. We looked at meeting minutes which showed issues such as housekeeping, safety, activities, changes in need and staff training needs were discussed.

There were clear systems for communicating with and referring to external services such as the community mental health team and health professionals. One person who lived at Oaklands House told us that the staff were responsive to health needs; "They listen to us and call the right people without delay. They all seem part of the same team and they work with us". A visiting professional told us, "The staff are really good, and will keep us updated. There have been a few minor issues with service users but they contact us straight away. Communication is really proactive." Any health and social care needs were noted in daily communication sheets; appointments made were kept in a daily diary and notes were kept from any visits from health and social care professionals.

When we toured the building we found that the design and adaptations suited the needs of the people who lived there. People's rooms were large and decorated and furnished to reflect their tastes and preferences. At the front of the building there was a large cosy lounge with tasteful carpets and wallpaper, leather settees and a large screen television which did not seem out of place. A visiting professional remarked, "It has a real homely feel and residents are encouraged to treat this as their home. It's always clean, it always smells nice". A second lounge near the back of the building allowed greater space and room for people to congregate or enjoy activities and pastimes. At the time of our inspection a conservatory was being redesigned, and staff were listening to suggestions from the people who used the service as to how this

space could be best utilised, for example, they were considering using it as a 'games room'. A garden area to the rear of the property allowed safe access to fresh air. However access at the time of our inspection was restricted for people who had difficulty with mobility. We saw plans had been developed to build a ramp which would allow wheelchair access. A smoking shelter had been erected for people to shelter whilst enjoying a cigarette.

When we last inspected Oaklands House people told us that they had to vacate the back lounge at 11pm as this became the staff bedroom. However, the service recognised that people's choice and access to community facilities for recreational activities and smoking were restricted by the staffing arrangements. Consequently they had moved the staff bed into the staff room. This meant that there were no longer any restrictions on people's access within the home.

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.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called Deprivation of Liberty Safeguards (DoLS). By law, the Care Quality Commission must monitor the operation of any deprivations and report on what we find. We checked whether Oaklands House was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met.

The manager told us, and we saw information to show that applications to deprive people of their liberty had been authorised or were awaiting authorisation. We had been informed where authorisations had been granted. Capacity assessments had been completed as part of the process to determine whether people needed a DoLS authorisation, and there was evidence to show that when an order was due to expire, requests for renewal were sent to the authorising body in advance.

At the time of our inspection only one person was subject to a DoLS order. When we looked at the person's care records we saw clear instruction with actions to take to ensure the person's safety and compliance with the authorisation. Staff we spoke with clearly knew the legal status of the people they supported and what this meant in terms of their interventions.

Good

Is the service caring?

Our findings

The registered manager told us that they put caring for people who used the service first. We saw people were treated as individuals; their values and beliefs were respected and people were treated with care and compassion by all the staff, who were without exception warm, friendly and open. Staff spoke warmly about the people they supported. They displayed a knowledge of their background, history and the support they required.

People told us they got on with the staff who, "Are all very nice". One person who lived at Oaklands House said, "I don't believe there is a better place, I've been here a long time now, and I love it, I wouldn't want to live anywhere else. Staff are always willing to help". We spoke to a person who visited Oaklands House on a regular basis. They explained, "[The service] doesn't have a high turnover so staff get to know people really well and develop good caring relationships. They provide care to a really high standard. My [service users] really like being here".

Staff were mindful that Oaklands House was where people lived first and foremost, and treated it as a home, rather than a workplace. This meant that care was person centred and interventions designed to meet people's needs in the way they wanted. One visiting professional said to us, "the staff go above and beyond to provide bespoke care. They don't appear to see it as a job; they do it because they care". We saw staff were considerate to people's wishes. We spoke with one person who lived at Oaklands House as they were completing a drawing. They told us, "I like drawing pictures, so they went out and brought me some felt tips. [Named staff member] is a charming lady, she brought in some books for me, she needn't have done that, but the staff are all very thoughtful".

Most of the people supported at Oaklands House could meet their own personal care needs and were encouraged to do so. Where people required assistance, staff were diligent and respectful of privacy. People were well dressed, groomed and clean shaven. Staff took time to support people to look their best. For instance, we observed a member of staff adjusting a person's dress. They displayed a very kind and caring approach whilst doing this.

During our inspection, we saw that in the dining room and conservatory there was a relaxed, pleasant and informal atmosphere. During the day people would occasionally retreat to the main lounge, which was peaceful and allowed for contemplation or quieter conversation. People were free to walk between rooms, and staff would stop and talk to them in a pleasant and person centred manner, or allow them privacy. The staff were kind, patient, friendly and caring towards the residents and all demonstrated a good rapport. Similarly people who used the service had developed good relationships with each other. One person told us, "I get on extremely well with the others, we all get on well".

We saw that people's personal belongings were treated with respect, and privacy was respected. For example, staff would knock on people's doors or ask for permission before they entered bedrooms. We were told that there were no set times for people to get up or go to bed and meals were provided when people wanted to eat rather than at set times.

People had access to independent advocacy services, and were supported to access these when required. Care records and information held about people was stored securely in the main office to maintain confidentiality and prevent information being used inappropriately. Records for people documented their interests and what they enjoyed doing. They indicated any specific cultural or religious requirements, and people told us they were supported to practice their faith. For example, one person told us that they attended mass every Sunday. The provider's provider information record (PIR) stated, "We respect the gender, race, religion or beliefs of the people we support. We support them in positive relationships with others regardless of the sexual preferences. At Oaklands House we support our residents say what they think about all aspects of their lives". People told us this was the case and that they were always offered choice in the delivery of their support, and involved in making decisions about their own care.

Good

Is the service responsive?

Our findings

People told us that care and support was delivered at Oaklands House in a way that was person centred and responsive to the needs of the people who lived there. A visiting professional said, "Oaklands House provides a really good service and really good support to people. Staff work hard to encourage people to develop their independence, for example, to self-medicate". A person who was supported at Oaklands House told us, "It is very good. The staff encourage us to do things, especially things we like, and to get out and about, so we don't sit and brood in our rooms".

Prior to their admission, the registered manager would complete a preadmission assessment. We looked at three assessments, all of which were comprehensive and provided detail about the person's background, occupation, general health, mental health issues, behaviour traits, relationships, exercise, hobbies, and religious spiritual and cultural needs. Further information detailed any personal care needs, medicines, environmental factors to consider, how the person communicated, and any household activities undertaken (such as housework, healthy choices, shopping and cooking). This was designed to understand the person's skills and abilities and to encourage independence. A further comments form highlighted any issues to be addressed on admission and was designed to consider if and how the person's needs could be met with consideration of the impact of admission on other people who used the service. This formed the basis of an extensive care plan which could be put into use from the first day of the person's admission into Oaklands House.

We looked at three care files. In addition to assessment and reviews these contained useful information about the person including personal details and contacts, local authority and mental health reviews, best interest decisions and a transfer to hospital summary, which was reviewed on a regular basis. A short profile showed how the person liked their care to be delivered. This would be helpful to anyone delivering care who was unfamiliar with the service. Daily records gave a good chronology of interventions with individuals and an indication of any changes in the person's presentation and health.

Each person attended their own monthly update and review. Notes of these meetings were kept in care files which noted attendance, and the person, any professionals, family and carers and staff. All aspects of care were considered to provide a generic overview of needs, progress and issues, and included comments from the person about their ongoing care and support.

Care plans contained information which gave a good outline of the individual's needs and preferences, and the actions staff should take to support the person to maintain their independence, meet their personal preferences, and reduce any potential risks. For example, one file showed a clear understanding of the person's primary diagnosis and how this can affect mood and behaviour. They Identified concerns, highlighted potential risks which were assessed, minimised and monitored. Plans gave clear instruction to staff to support the person in the way they wanted support to be delivered, and specific specialist information and guidance from the relevant professionals involved in people's care was contained within the care records. Another plan we looked at showed clear oversight and monitoring of health needs, with vigilance and review of care plans on a daily basis, liaison with the person's community psychiatric nurse

(CPN) and mental health team. The person had an independent advocate and their interventions and advice were recorded. People who used the service told us that they were consulted about their plans and were asked to sign to say that they agreed with them.

Care plans reflected the person centred approach we witnessed, and recognised that poor mental health could lead to unwise decisions which could increase the risk of harm. For example, we saw care plans which showed people would choose to self-prescribe by seeking and using illicit substances. This increased the risk of not only damage to health and lead to financial debt, but also to criminal activity and conviction. Where this was the case we saw the service worked closely with the people involved, highlighting the risks and suggesting alternative ways of meeting need without restricting people's right to self-autonomy. A visiting professional believed the service was looking to support people to make their own decisions but recognised when the decision could be harmful. They told us, "I am confident that people's needs won't be neglected. Any issues and I'll be consulted, and they will talk and listen to the service users to negotiate a reasonable settlement". We saw the service had liaised with community police and mental health professionals to manage risk, and people who used illicit substances had agreed to sign behavioural contacts regarding their behaviour in the home, with final warnings issued if their behaviour became intolerable to other people who used the service. Care plans instructed staff to monitor for signs that people may be under the influence of illicit substances, for example, and reflected any changes this might impact on the person. We spoke to one person, who told us that they understood why this was the case, and had agreed to follow their behaviour contract.

The service ensured people were stimulated and throughout our inspection we saw friendly and meaningful interaction between the staff and the people they supported. A visiting professional told us, "Clients I've had here love it. They are always well presented and encouraged not to lie in bed all day. It's as close to being in their own home that residential care gets". We saw staff would spend time with the people they supported, either sitting and talking with them or empowering them by providing support to engage in activities around the home which would maintain their skills and encourage their independence, such as shopping, laundry or baking. One person who used the service said, "I like living here, I have enough to do. I can go out with staff every day".

All the people we spoke with were able to describe how they were encouraged and supported to maintain their hobbies and interests, and we saw that people were supported to access activities in the community. Where people who used the service had difficulties either due to physical or mental health difficulties, staff would escort them on trips, or invite them to accompany staff for example, to the supermarket to choose and buy provisions for the home. The staff also arranged trips out on a regular basis. For example, we overheard a member of staff who was taking two people they supported on an upcoming day trip to Blackpool asking them what they would like to do. We were told that the service also arranged outings with a local coach firm who had got to know the people who lived at Oaklands House and agreed to discount the price of trips and days out. One person who used the service told us that staff had arranged for a small group to go out to a local restaurant the following day to celebrate a birthday.

We looked at how the service managed complaints. We saw that the service had a complaints policy and people who used the service told us that they were aware of how to complain if they needed to. One person said, "If I have any problems I can go to the [registered manager]. She'll sort it out for us." We saw that the service kept a numbered log of all complaints and analysed this on a regular basis. Action had been taken to investigate each complaint and we saw that outcomes were noted, including apologies where complaints were substantiated, and evidence of action to prevent reoccurrence. Where complaints related to the behaviour of people who used the service and the effect on others, records showed arbitration and mediation by staff to resolve the difficulties.

Most of the people who used the service were younger adults, and there had not been any recent deaths at the service. When we spoke to managers and staff they demonstrated a good understanding of end of life care, and how they would support people to spend the last days of their life in accordance with their wishes.

Good

Is the service well-led?

Our findings

One person reflected the views of all the people we spoke with about how the service was managed. They told us, "I have lived at Oaklands House for 15 years and I am happy here. I love having my support staff. They are very good with me and have helped me through a lot of things and I am so happy with how the home runs. All the staff are excellent and I would tell that to the whole world".

We saw staff were highly motivated and worked together as a team They understood the nature of service, the level and type of people who they supported and how best to respond to them. They understood that people who lived at Oaklands House had severe and enduring vulnerabilities. But they had established a gentle and good relationship with the people they supported, and by adopting a proactive approach to need they had helped them to maintain good mental health. A visiting professional told us, "It is a very supportive regime, gentle and caring. It's such a lovely home. I couldn't find fault with the service, the manager, or all the staff. The person I support feels happy here".

A visiting professional told us, "This is a good service. People have a sense of ownership of the premises and the service. They are given freedom but with the right support as necessary. The people here were very unwell prior to coming here, but are well supported and show much improvement in their mental health and well-being."

It is a requirement under The Health and Social Care Act that the manager of a service like Oaklands House is registered with the Care Quality Commission. When we visited the home had a registered manager who has been registered as manager for over three years. She had previous experience working in a variety of service provision and had developed a wide and varied knowledge specific to mental health issues. A member of staff told us they believed the registered manager was, "The best we've had, approachable, supportive. We get good and appropriate supervision both on and off the job. I can always get advice and help when I need it from her or the deputy manager." And a visiting professional said, "[The registered manager] is really good. She understands mental health and shows a careful and considered approach to meeting need. She is knowledgeable about drug and alcohol, and keen on social inclusion". She showed a clear understanding of her role and was aware of her responsibility to pass on any concerns about the care being provided, including notifications to the Care Quality Commission (CQC) and local authority commissioners.

When we asked people who used the service, they agreed that she was a good and caring manager. They told us, and we saw that the registered manager was visible around the home every day when on duty. We saw a compliment written by a person who used the service which read, "I am so happy you came to Oaklands House, I think you do a fabulous job. The best manager we have had".

The registered manager told us that the owners were supportive and made regular visits to the service. They would listen to any requests for resources, for example, they had recently increased the food budget.

We looked at minutes from resident meetings which were held on a regular basis. These meetings gave

people who used the service an opportunity to raise any issues of concern and reach a collective agreement on issues which affected how the service was managed. Recent discussions at residents meetings included consideration of how best to utilise the conservatory, further communal activities and the problems of working within personal budgets, and food choice and provision. Meetings were well attended. We saw that the service also used these meetings to inform and educate people in a relaxed and informal way, for example, by conducting quizzes on road safety or fire safety. People told us that they enjoyed these quizzes, and found them informative.

The service also sought feedback from people supported at Oaklands House by conducting a survey every four months. We looked at the most recent survey, which covered all aspects of care delivery. Not all people had completed this survey but all that had gave a positive response to their care and support.

The registered manager had developed a system to audit all aspects of service on a daily, weekly monthly or longer basis. For example, we saw medicines checks were carried out on a daily basis, Reports covered staffing, training, resident issues, audits of reviews and care plans, incidents, and medicines. We saw checks on expiry dates of medicines, with a full medicine audit every three months, and each person who administered medicines had a three monthly competence check carried out by the registered manager. We looked at further audits conducted around cleaning and infection control, including a daily audit of rooms and audits of care plans. Where errors or concerns were identified these were investigated to prevent any future occurrence.

We saw that all policy and procedures were regularly updated to ensure that they conformed to the most recent guidance, best practice and legal requirements, and encouraged self-independence. For example, a 'managing service user's finances procedure encouraged staff to allow people they supported to take control of their own finances, and support them to do so.

We checked records regarding the maintenance and upkeep of the premises. Although there was no maintenance officer we saw that any repairs required were logged and quickly carried out by appropriate contractors. Records were kept showing that checks on all aspects of building upkeep had been carried out, including gas safety, electrical tests, fire risk assessment and emergency evacuation procedures and checks to prevent legionella. A timetable showed when these checks were next due.

We saw that the service worked well with local stakeholders and actively sought support and collaboration with relevant external agencies.

Visiting professionals told us that the service would contact them as and when necessary and listened to their advice. When we contacted stakeholders prior to our visit, they told us that they had no concerns about the service or how it was managed.