The Oaklea Trust

The Oaklea Trust (North West)

Inspection report

Second Floor, East Wing
Station House Station Road,
Kendal
LA9 6SA

Tel: 01539735025
Website: www.oakleatrust.co.uk

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Ratings

Overall rating for this service	Inspected but not rated

Is the service safe?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

About the service
The Oaklea Trust (North West) provides personal care and support to people living in their own homes in the South Lakeland and Furness districts of Cumbria. The service is managed from offices in Kendal.

The service provides support to people living in nine supported living houses in Kendal, Barrow-in-Furness and Ulverston. It also supports people living in their own homes in the community. At the time of our inspection the service supported 27 people with their personal care. The service supported people who had a learning disability and/or autism and/or a physical disability.

Not everyone who used the service received personal care. CQC only inspects where people receive personal care. This is help with tasks related to personal hygiene and eating. Where they do we also consider any wider social care provided.

People's experience of using this service and what we found
The systems to assess and manage risks had not always ensured people were protected from the risk of harm. The provider had systems to learn and improve the service. They took action to improve the safety of the service during the inspection. There were enough staff to support people. Staff were trained in how to identify and report abuse. People received their medicines safely. People were protected from the risk of infection.

The systems used to assess and monitor the quality and safety of the service had not identified where improvements needed to be made. People were asked for their views about their support. The provider worked cooperatively with other agencies. The provider arranged for additional management oversight and support to improve the service.

We expect health and social care providers to guarantee autistic people and people with a learning disability the choices, dignity, independence and good access to local communities that most people take for granted. Right Support, right care, right culture is the statutory guidance which supports CQC to make assessments and judgements about services providing support to people with a learning disability and/or autistic people.

Based on our review of safe and well-led key questions the service was not able to demonstrate how they were meeting some of the underpinning principles of Right support, right care, right culture. Some aspects of the service were not always safe and people were placed at risk of harm. Staff were caring to people and supported them to follow activities they enjoyed. People were given choices about their lives and their independence and dignity were promoted.

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

Rating at last inspection

This service was registered with us on 14 November 2019 and this is the first inspection at this address. The service was previously registered at another address. The last rating for the service at the previous premises was good, published on 14 March 2019.

Why we inspected
We received concerns in relation to how the provider ensured people were protected against the risk of abuse. As a result, we undertook a focused inspection to review the key questions of safe and well-led only.

We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. We will inspect the other key questions at our next full inspection of the service.

We have found evidence that the provider needs to make improvement. Please see the safe and well-led sections of this full report.

The provider had identified areas of the service which needed to be improved and had provided additional senior manager support and oversight to address issues found.

Enforcement
We have identified breaches in relation to the management of risks at this inspection.

Please see the action we have told the provider to take at the end of this report.

Follow up
We will request an action plan for the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Details are in our safe findings below

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below.

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Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

Inspection team
The inspection was carried out by one inspector and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
This service primarily provides care and support to people living in nine 'supported living' settings, so that they can live as independently as possible. People's care and housing are provided under separate contractual agreements. CQC does not regulate premises used for supported living; this inspection looked at people's personal care and support. The service is also a domiciliary care agency. It provides personal care to people living in their own houses and flats in the local community.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

We gave the service 24 hours' notice of the inspection. This was because we needed to be sure that the provider or registered manager would be in the office to support the inspection.

Inspection activity started on 19 August 2021and ended on 19 November 2021. We visited the office location on 19 August 2021 and contacted people who use the service, their relatives and staff after our visit to the office. We arranged, with people's agreement, to visit one of the supported living houses on 13 October 2021

and spoke to staff who worked in the house following our visit.

What we did before inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report. We used all of this information to plan our inspection.

During the inspection
We visited the office location and spoke with the registered manager and a manager responsible for overseeing some of the supported living services. During our visit to the office we looked at care records for two people and records related to the management of the service. We spoke by telephone with two people who used the service and 14 relatives about their experience of the care provided. We visited a supported living house and spoke with two people living there and observed how staff interacted with people. We looked at care records for two people who lived at the supported living house. We contacted nine staff by telephone and email to gather their views of the service.

We reviewed a range of records related to the safety and management of the service. This included staff training and recruitment records, audits and how the provider assessed the safety of the service.

Requires Improvement

Is the service safe?

Our findings

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

This is the first inspection for this newly registered service. This key question has been rated requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Systems and processes to safeguard people from the risk of abuse; Assessing risk, safety monitoring and management

- Although the provider had systems to assess and manage risks, these had not ensured complete and accurate records were available to guide staff on how to ensure people's safety.
- Some people who used the service were identified as vulnerable to the risk of abuse. We asked the registered manager for evidence showing how they had ensured possible risks to people had been considered before the service agreed to provide their personal care and support in a supported living property. The registered manager assured us the potential risks would have been considered, however they were not able to provide evidence of this and we could not be assured the risks had been considered.
- One person's care records identified specific risks to their safety and instructions for staff on how to mitigate the risks. We observed the guidance for staff was not fully followed, placing the individual at risk of harm. This was immediately addressed by the provider.
- Staff had been trained in how to identify and report abuse. They were knowledgeable about people they cared for and how to protect them from harm.
- People who used the service said they felt safe. Relatives we spoke with said they were happy their family members were safe.

We found no evidence that people had been harmed however, systems to identify and manage risks were not robust. This placed people at risk of harm. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

- There were enough staff to meet people's needs. People told us they liked the staff who supported them.
- In common with many adult social care services, the provider faced some challenges around staffing. They had experienced significant staff turnover and were actively recruiting for additional staff. Some relatives told us they had noticed high staff turnover and said this could impact on the care provided while new staff got to know people and how they wanted to be cared for.
- The provider carried out checks on new staff to ensure they were suitable to work in the service.

Using medicines safely

- People received the support they needed to take their medicines safely.
- Staff completed training in how to manage and record medicines they had given to people.
- People were supported to manage their own medicines.

Preventing and controlling infection

● The staff protected people from the risk of infection. They had been trained in using Personal Protective Equipment, (PPE) effectively to protect people from the risk of infection.

● The staff had given people advice, in a way they could understand, to maintain their safety during the COVID-19 pandemic.

● Relatives told us they had seen staff wearing PPE in line with guidance.

Learning lessons when things go wrong

● The provider and registered manager had systems to learn lessons when incidents occurred. They used feedback received during the inspection to make improvements to the service.

Requires Improvement

Is the service well-led?

Our findings

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

This is the first inspection for this newly registered service. This key question has been rated requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of safe, high-quality care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- The systems used to audit the service had not identified issues we had found regarding managing risks to people's safety. The provider took immediate action during the inspection to improve the safety of the service.
- The provider had made changes to the management arrangements for the supported living houses. Each property was overseen by a team supervisor, who reported to a team manager. The team managers were responsible for a number of supported living properties. The team managers reported to the registered manager for the service.
- Although most people received person centred care, which promoted good outcomes, we received negative feedback regarding support provided in one area where care was delivered. Some people told us the quality of the service had deteriorated following the changes to management arrangements. One person said, "Over the years it was very good. A fantastic team. Then [with the] changes, I found care seemed to go down. The good manager left, and the dynamics changed." Another person said, "Communication is deteriorating. The last manager left. [They were] good with residents. The manager now covers five homes."
- The provider had identified the need for further support in some areas of the service. They had arranged for additional management oversight and support for the team supervisors.

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

- The provider was aware of their responsibilities under the duty of candour. They shared information about incidents with relevant people. One relative told us, "They keep us well informed."

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- The provider had formal and informal systems to gather people's views. Before the pandemic, the provider asked people who used the service and their relatives to complete quality surveys to share their views. In response to the pandemic the provider had developed electronic systems to seek people's views. The provider had taken action in response to feedback received including providing activities which took account of individuals' preferences.
- Staff in each supported living property also asked for people's views. People were included in choosing their meals and a range of activities which were reopening in the community.

● Staff told us they could make suggestions for how the service could be improved. This included identifying activities people may enjoy.

Working in partnership with others; Continuous learning and improving care

● The provider worked cooperatively with other agencies to identify how the service could be improved and to take action where required to ensure the quality and safety of the service.

● The provider used verbal feedback given during the inspection to take immediate action in response to issues we found.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment How the regulation was not being met: Systems to identify and manage risks were not robust. This placed people at risk of harm. Regulation 12 (a) (b)